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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums, and Allied Institutions, and to their Medical, Surgical and Nursing Services

Vol. I December, 1913 No. 4

ORGANIZATION OF DEPARTMENTS OF A LARGE GENERAL HOSPITAL.[1]

Showing the Manner in Which the Hospital, the University and the Medical School Are Bound Together by a Board, Advisory Board and Medical Board.

By RUPERT NORTON, M. D.
ASSISTANT SUPERINTENDENT, JOHNS HOPKINS HOSPITAL.

As the relationship of the Johns Hopkins Hospital to the Johns Hopkins Medical School and University is not generally understood, it is well to refer for a moment to the foundation of the hospital to make these points clear.

It was due to the remarkable foresight and wise thought of Johns Hopkins that he indicated to the first trustees of the hospital the future role of the hospital as an integral part of the university, as expressed in the following quotation from his letter to the trustees, dated Baltimore, March 10, 1873:

> "In all your arrangements in relation to this hospital you will bear constantly in mind that it is my wish and purpose that the institution shall ultimately form a part of the medical school of that university, for which I have made ample provision by my will."

A close bond has existed since the beginning between these two foundations of Johns Hopkins through the fact that there are common members on both boards of trustees. At the present time there are three gentlemen who serve as trustees to both the hospital and the university. In this way business which affects both corporations is easily transacted, since questions of common interest which come to one board can easily be brought before the other.

The affiliation of the hospital with the medical school is effected in another way. The professors of medicine, surgery, gynecology, and other clinical branches are made physicians or surgeons-in-chief to the hospital. The nominations for these positions on the hospital staff are made by the so-called advisory board and brought through the medical board—of which more in a moment—to the trustees of the hospital by the superintendent, who acts as the intermediary between the school and the trustees, who ratify all appointments. The nominations have also to be ratified by the university authorities, and this is accomplished through the medical faculty, which submits its proposals to the university trustees. In case some difference of opinion arises between the medical school and trustees of the hospital as to the wisdom of a nomination, it is taken up by a committee of both parties and settled. The medical board, of which I have just spoken, is composed at the present time of the professors of medicine, surgery, gynecology, obstetrics, children's diseases, psychiatry, and pathology, the two professors of clinical medicine and clinical surgery, and the superintendent. In addition to these boards and committees, there are two other committees on which the superintendent serves—the executive committee of the medical faculty, consisting of three members (the president of the university, the dean of the medical faculty, and the superintendent), and the committee on graduate instruction, also of three members (the dean of the medical faculty, the professor of medicine—at the present time—and the superintendent). It is not worth while here to specify accurately what the duties of these two boards are, and I mention them merely to indicate the intimate connection that the superintendent of the hospital has with the medical school. This, in a

[1] First of a series of eight papers on the organization and administration of a large general hospital, prepared under the direction of Dr. Winford H. Smith by his associates in Johns Hopkins Hospital.

few words, shows how these bodies are united and work together.

The full board of trustees of the hospital meets once a month with the superintendent, in his office at the hospital, and its executive committee meets also once a month two weeks earlier (or later) than the trustees at the same place. The morning of the day preceding the meeting of the trustees the medical board meets in the superintendent's office and submits to him all matters relating to the medical organization of the hospital (the care of patients, new appointment of interns, etc.) which demand the ratification of the trustees.

The superintendent, or active managing head of the hospital, is appointed by the board of trustees and is intrusted by them with the entire care of the hospital, the actual care of the patients being left to the physicians and their assistants (residents and interns). The superintendent has all the ordinary duties of such an officer to perform, and it is not necessary for me to enlarge on these, but merely to state and to emphasize the fact that the trustees *never interfere with his 'prerogatives, or give any orders except through him.* This is a point most worthy of attention, for many boards of trustees fail to appreciate what their own proper duties are, and are constantly and improperly interfering with the superintendent's work. The superintendent is the medium through whom all persons engaged and employed by him can reach the trustees, and only through him can complaints of any sort pass.

The superintendent has as his immediate assistants three men—one who relieves him of many of the details of administration, exercises general supervision of the work in the wards, and, in addition to a variety of duties, is also the editor of the hospital publications (The Johns Hopkins Hospital Bulletin and Reports); one the admitting officer, and another in charge of the outpatient department.

In charge of other departments of the hospital are (1) the superintendent of nurses, (2) the matron, (3) the dietician, (4) the engineer, and (5) the pharmacist. All these heads of departments have their assistants, selected by them. The superintendent selects his own immediate assistants and these five heads of departments, who in turn select their own staff without interference by him, though always with his approval. The superintendent holds a daily morning conference with all heads of departments individually.

The training school for nurses which Johns Hopkins so happily established was referred to in his original letter as follows:

"I desire you to establish in connection with the hospital a training school for female nurses. This provision will secure the services of women competent to care for the sick in the hospital wards, and will enable you to benefit the whole community by supplying it with a class of trained and experienced nurses."

The school now numbers 154 pupil nurses, calling for an administrative staff of 32. The staff includes the superintendent of the training school, her immediate office assistants, and the graduate nurses in charge of the wards. The office assistants have various duties, such as teaching, charge of the surgical supply room, observation of ward work, etc., of which more will be said in a forthcoming paper. The nurses' home is under the care of a housekeeper. The assistants and the housekeeper are all graduate nurses. In addition to the pupil nurses, we have a few post-graduate nurses studying in different departments (children's diseases, psychiatry, etc.); also some pupils of other schools in the city, and a large body—fifty, more or less—of special nurses with private patients.

The matron is also a graduate nurse. She has full charge of the laundry, through which pass weekly between 55,000 and 60,000 pieces, and of all the cleaning of the hospital, with the exception of the daily work in the wards (under the care of the superintendent of nurses) and the nurses' home. She has also to purchase all the housekeeping supplies, furniture, and bed linen for the interns' rooms, china for the dining rooms, and supplies of many sorts needed in different departments. Of necessity she has aids, but no nurses to help her, except as a part of a post-graduate course in administration.

The dietician trains the pupil nurses in dietetics; prepares, with her assistants, two in number, all the food for the private patients and special invalids in the public wards, oversees the butcher and baker, and has general control of the kitchen, the doctors' dining room, the help's dining room, and the purchase and distribution of all fresh and cooked food throughout the hospital. The nurses' home has its own kitchen, although all the requisitions for food pass through the office of the dietician. The menus for the nurses and the direction of the kitchen are under a trained dietician, an assistant of the dietician in the main kitchen.

The chief engineer is also superintendent of grounds. Under him are the men who run the hot-water and steam boilers, the electricians, the men who make the ice, and other employees, such as the elevator men and the gardeners.

The pharmacist purchases most of the drugs, as well as rubber goods, glass syringes, etc., needed throughout the hospital. With the help of his two assistants, he dispenses drugs in the

out-patient department, and also prepares some tinctures, ointments, etc. To the pupil nurses during the first six months of their three years' course he gives lessons in pharmacology and materia medica.

Our baggage room is under the direction of one of the assistant superintendents, as are the painter and the carpenter under another. All the ward orderlies and maids are selected and directed by one of the office assistants of the superintendent of nurses. The maids in the nurses' home are in the same way chosen and managed by the matron of the home, while all other maids, except those in the kitchen and dining rooms, are a part of the matron's department.

Thus it is seen that, so far as possible, the duties of the different departments are kept quite separate, and the head of each is held responsible for its proper administration by giving him or her full power to select his or her own help, and leaving the head to develop his department along the lines he thinks best, but subject to the approval of the superintendent. There is one essential control, however, which lies in the superintendent's hands, and that is the purse string. All requisitions for supplies of whatever nature—stationery, nurses' clothes, drugs, and matron's, dietician's, and housekeeper's needs, etc.—must all be authorized by him.

Of the bookkeeping office I have not said a word. It seems merely necessary to mention it, so that the readers may not think it forgotten. But the duties here are practically the same as those in the same office of other hospitals. The business affairs of the hospital corporation are transacted at the office of the corporation, which is not in the hospital, and from this office all bills are paid.

Such is briefly the administrative organization of the hospital, but before closing it may be well to add a few words in regard to the medical organization and the presence of medical students in our wards, since this feature is almost unique with this hospital, although in use by other hospitals with more or less modification.

Each staff—medical, surgical, gynecological, etc.—is under the immediate direction of the physician, surgeon, or gynecologist-in-chief. The chiefs are paid salaries, half by the university and half by the hospital. Each chief has his house staff, consisting of a resident (who is also paid a salary by the hospital), assistant residents, and interns. The number of members on each staff varies with the amount of work done by one or the other. Appointments are all for one year, but the residents are usually reappointed on the medical and surgical staffs, so that they may serve for two, three, or more years. There is no rotation of service—i. e., an intern appointed to one service serves his year's appointment on that service alone. The interns, with but very few exceptions, are graduates of the Johns Hopkins Medical School. A few men from other schools are from time to time selected to serve as interns, and are admitted on their past records without examinations. The residents are men who have, so to speak, risen from the ranks, serving first as interns and then as assistant residents, in which latter capacity on the medical side they may have had very broad experience as head of some one or more of the medical laboratories. The present resident staff, including three pathologists, consists of over fifty members. Women graduates of the medical school are selected as interns if they hold the necessary rank on graduation, and may serve in the medical, gynecological, obstetric, pediatric, and psychiatric departments. The medical staff is the largest, and will serve as an example of the composition of all. At its head is the resident, with six assistants and four interns. There are, in addition, four more residents in charge of the medical, bacteriological, chemical, and tuberculosis laboratories; and finally the clinical laboratory, in which the third-year students are taught the examination of blood, urine, feces, gastric contents, etc. The other staffs have not so many assistants, nor so many laboratory appointments.

At the end of the second year of the medical school curriculum, during the last trimester, students are permitted to work in the dispensary. Previous to this time they have had no connection with the hospital. In the third year their training is carried on still further in the dispensary, and in the fourth year they are admitted as clinical clerks to work in the wards under the direct control of the intern in charge of the ward. The fourth-year class is divided into groups, and each group in turn serves in the medical, surgical, gynecological, and pediatric departments. To these clerks are assigned definite duties by the intern—for instance, taking of histories, making blood and urine examinations, etc. Above the intern is the assistant resident and resident, and responsibility for the performance of duties falls thus ultimately on the resident, but he instructs his assistants as to what they are to do, and so is relieved of watching over all details.

During the last two years of the medical student's training he lives practically within the hospital, in close touch with patients. In the fourth year there are rounds in the public wards several days a week, conducted by the chiefs (physician, surgeon, etc.) or their associates, for the teaching

staff of the medical school consists of professors, associate professors, associates, assistants, etc.

It is impossible in this article to enter further into this branch of the hospital administration, but I may close by stating that, in spite of all the additional work and expense entailed by the presence of students in our wards, we rejoice to have them, and could not get on without them. They are of benefit to the patients and to the reputation of the hospital.

SOME SPECIAL FEATURES OF THE NEW COOK COUNTY HOSPITAL.

Nucleus of What Is to Be a 3,000-Bed Hospital—Ward Arrangement—Operating Department—Work Rooms—Radiographic Suite.

By RICHARD E. SCHMIDT, County Architect, Chicago.

THE new Cook County Hospital is not to take the place of the whole of the existing institution. The children's, contagious, tuberculosis, children's tuberculosis, morgue and service buildings, and boiler and engine houses are to remain, and a detention (psychopathic) hospital is being built at the south end of the grounds.

Fig. 1. Cook County Hospital—Administration front.

The new hospital building is to accommodate the administration rooms, operating department, 656 patients and 71 interns. The building extends along West Harrison street, between Wood and Lincoln streets, for a distance of 500 feet, with its main front toward the north. It has two ward pavilions, one adjacent to South Wood street and the other to Lincoln street, extend toward the south—i. e., their longitudinal axes are on north and south lines. Two additional similar pavilions were planned, but have not been placed under contract, and it is hoped that funds will be available early in 1914 to permit building these,

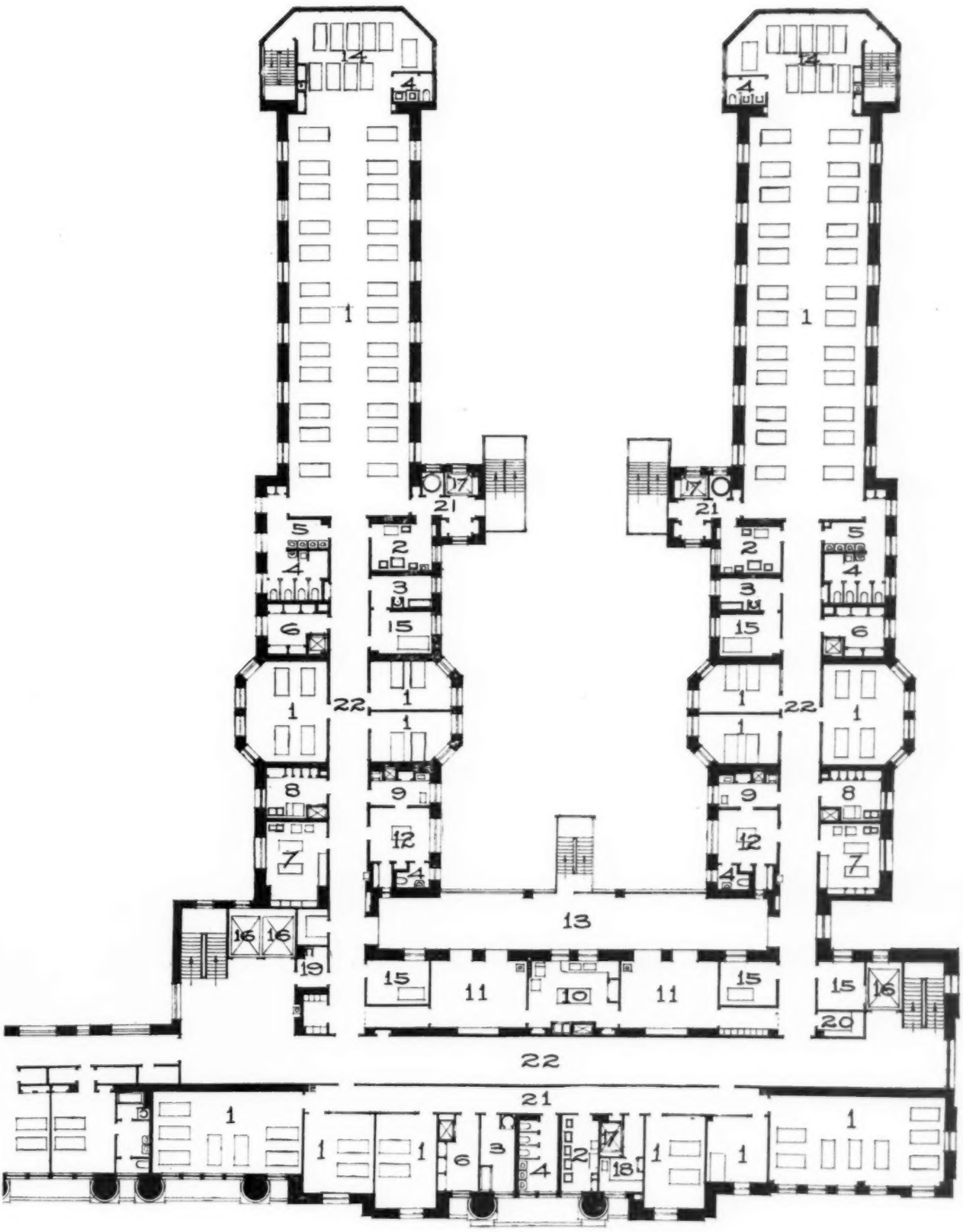


Fig. 2. Cook County Hospital—Plan of pavilions.

1, ward.
2, utility room.
3, bath room.
4, toilet.
5, wash room.
6, linen room.
7, dressing room.
8, diet kitchen.
9, medicine closet.
10, serving pantry.
11, dining room.
12, nurses' room.
13, porch.
14, solarium.
15, quiet room.
16, passenger elevator.
17, freight elevators.
18, laboratories.
19, mop closet.
20, surgical appliance closet.
21, passage.
22, corridor.

which will afford an additional capacity of 320 beds.

Inasmuch as it will be necessary to raze many of the old buildings if these two pavilions are built, all of the buildings on the grounds will then be of fireproof construction. The total normal bed capacity will be about the same as before the construction of the new building was begun, but there will be enough vacant space on the ground for the building of additional units to obtain an ultimate capacity of 3,000 patients' beds.

The ward pavilions have a first floor at the level of the ground, which is to be used for food and linen cart service to the dumb waiter and elevators, five floors upward, and a roof garden, with a bed pans, a large work sink, a utensil sterilizer, marble shelves, and a hand basin. Room 3 is a bath room, and will have a tub and shower bath. Room 4 is a toilet room, with water closets separated from the wash room, which is room 5. Room 6 is a linen room, connected to the ground floor passageways by a push button dumb waiter, so that linen need not be disturbed by carting around on the ward floors. Room 7 is a surgical dressing room, and room 8 a diet kitchen connected to the ground floor passageways by an electric push button dumb waiter. Room 9 is a medicine room, also connected to the ground floor by dumb waiter.

The plan contemplates the serving of food to

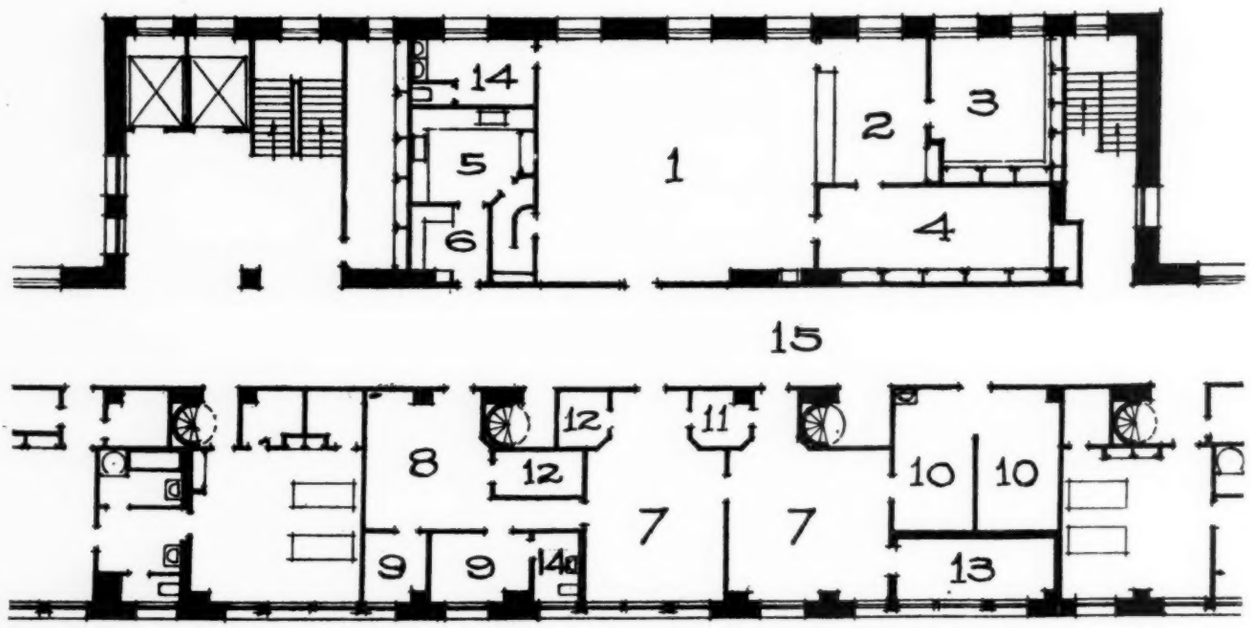


Fig. 3. Cook County Hospital—Radiographic suite.

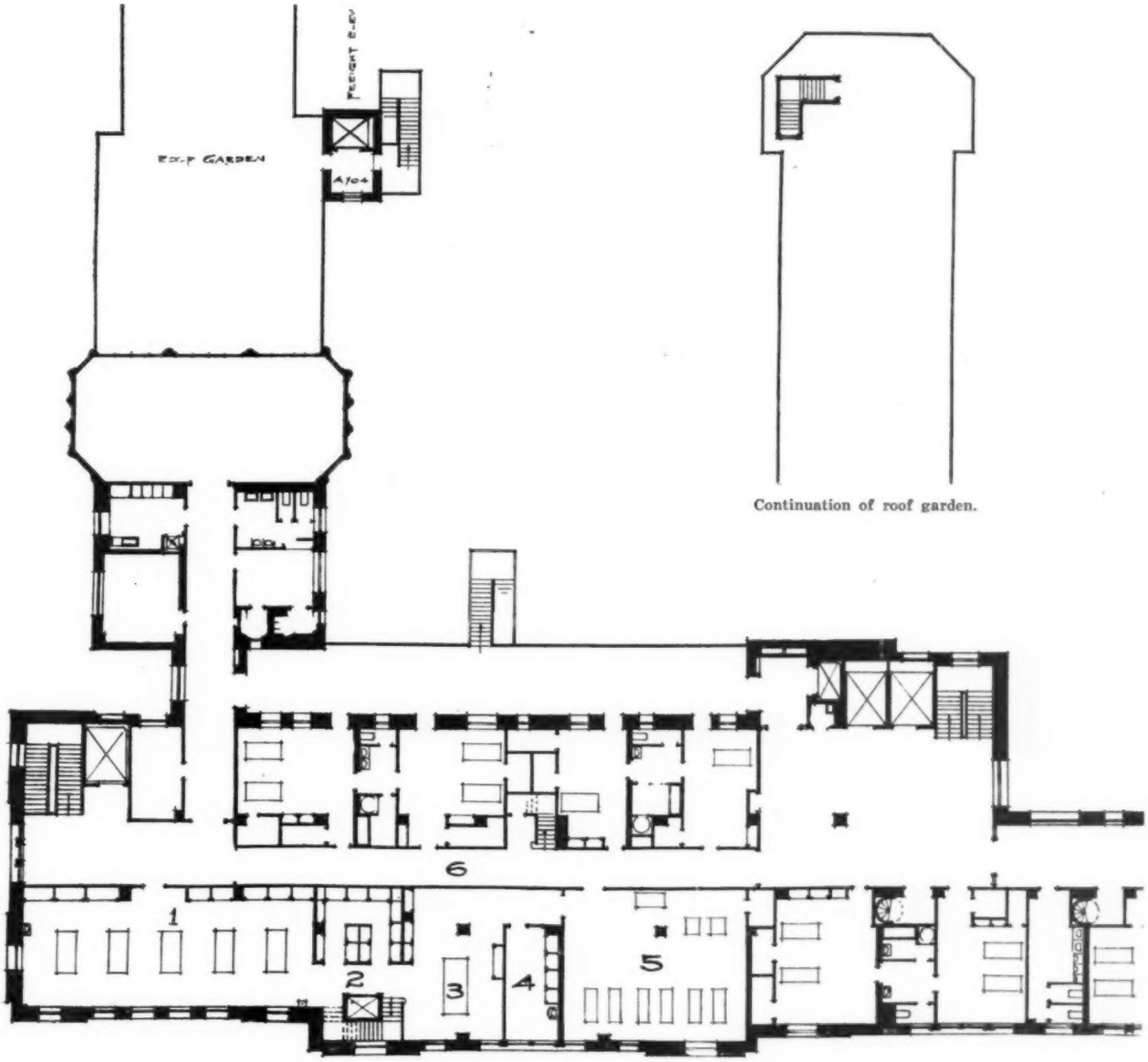
1, waiting room. 2, office. 3, library. 4, consultation and exhibition room. 5, dark room. 6, supply room. 7, radiographic room. 8, fluorographic room. 9, preparation room. 10, treatment room. 11, operator's booth. 12, instrument room. 13, generating apparatus room. 14, toilet. 15, corridor.

roof sun parlor, toilet, and serving and dining rooms.

A plan of the pavilions is shown in the illustration (Fig. 2). It will be seen that the main wards are each arranged for 24 beds, and have a width of 27 feet by a length of 85 feet, with windows on two sides. A sun parlor is at the extreme south end of each ward, with an inclosed fire escape stairway and a toilet room. The sun parlors are divided from the wards by glazed accordeon doors, which will fold into pockets on each side of the opening. In addition to the main ward, each pavilion has one 4-bed and two 2-bed wards for more acute cases, or for patients who are likely to disturb other ward patients.

Room 2 (Fig. 2) is a utility or slop sink room, which will have the usual slop sink for cleansing each pair of pavilions from one serving room, marked room 10. The adjacent room, marked 11, will serve as a dining room for convalescent patients and ambulatory patients who assist in serving the bed patients with food. The length of the pavilion and distance from beds to auxiliary rooms seems greater than could be obtained by another arrangement, but the dimension area per bed and sunlighting are adequate. Room 12 is a nurses' office, with a nurses' toilet, lockers, closet, and book case. The porch marked 13 is also between the pairs of pavilions, and is designed for the use of the patients of both.

The portion of the north front of the building which is not used for administration and operating department purposes is divided into ward units, being from 22 to 30 beds each. Each unit



Continuation of roof garden.

Fig. 4. Cook County Hospital—Work rooms and operating department.

1, work room.
2, linen room.
3, drum filling room.
4, bandage room.
5, general sterilizing room.
6, corridor.
7, passage.
8, sterile supply store room.
9, distributing room.
10, nurses' room.
11, nurses' locker room.
12, nurses' bath.
13, nurses' toilet.

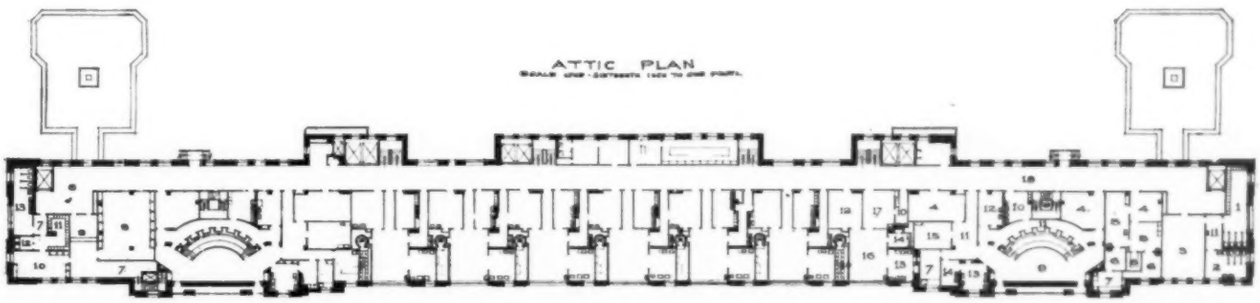


Fig. 5. Cook County Hospital—Operating department.

1, doctors' locker room.
2, doctors' toilet room.
3, surgeons' library.
4, waiting room.
5, examination room.
6, treatment room.
7, laboratory.
8, supplies.
9, clinic.
10, doctors' scrub room.
11, passage.
12, etherizing room.
13, sterilizing room.
14, nurses' scrub room.
15, dressing room.
16, orthopedic operating room.
17, plaster room.
18, corridor.
19, students' chair.
20, students' balcony.

is complete, having utility, bath, toilet, and linen rooms, and also a small laboratory.

The radiographic department is on the seventh floor, immediately below the operating department, and the key of the rooms in the accompanying illustration (Fig. 3) indicate the purpose of each room. The total space occupied is approximately 4,000 square feet, and appears to be a liberal and convenient arrangement.

Fig. 4 illustrates the work rooms of the operating department, having a general work room, linen room, drum filling room, bandage room, and a general sterilizing room. The latter is arranged to receive six 16 by 60-inch dressing sterilizers, set in pairs, and one large size salt solution sterilizer. This department is also in the seventh story, immediately below the sterile supply store room, distributing room. operating nurses' bath, and toilet and locker rooms on the eighth floor.

The eighth floor contains the operating department, and is shown in the illustration (Fig. 5). It occupies the whole length of the Harrison street frontage, with an area of approximately 31,000 square feet, an unusually large and spacious arrangement. It contains two amphitheaters, each having a seating capacity of 120 students, and 7 operating suites, each having an operating room 17 by 23 feet, and anesthetizing room, doctors' scrub room, stand or balcony for 16 students, sterilizing room, and nurses' scrub room. The two large amphitheaters have similar auxiliary rooms. The instrument room and instrument distribution room are centrally placed in the middle of the length of this department, across the corridor.

Students and other observers of operations are not to be allowed access to the operating room floor, but are to be taken to the seventh floor by elevator, and will there pass along the corridor to stairways which lead directly into the observing balconies or to the amphitheater seating in the two large clinics. There are no doors from these special stairs in the eighth story, so that no one can pass into it.

Tin-lined pipes have been laid from a central point to all basins, sinks, and water sterilizers in this department. A large water sterilizer or still is to be installed at a central point, pairs of 6-gallon water sterilizers are to be placed in each one of the sterilizing rooms of the nine operating suites, with faucets extending through the partitions and discharging water over a sink in the operating room. Each of these sterilizing rooms is to have a utensil and an instrument sterilizer.

The daylight illumination is from the north by adequate windows and skylights, and the floor equipment and lighting fixtures will be of the best modern materials and design, so that this hospital will have one of the largest and best operating departments in existence.

THE FUNCTION OF THE MODERN HOSPITAL IN PREVENTIVE MEDICINE.

Must Assume Relationship of Old-Time Family Doctor—Life Histories of Patients Are Key to Causes of Disease—Research Work Should Broaden Out.

By H. S. MATHEWSON, M. D.
SURGEON UNITED STATES PUBLIC HEALTH SERVICE, QUARANTINE STATION, PORTLAND, MAINE.

THE history of hospital development in the United States is of great interest when viewed from the increase in function which has taken place in the past one hundred and fifty years. Some years before the Revolutionary War, hospitals were established in New York and Philadelphia simply for the care of those who were sick or injured. A few years later insane patients were cared for on the ground that they were ill and needed hospital treatment, rather than confinement in jail or prison as incorrigible. Early in hospital development we see the field of the hospital as a place for the education of young medical men gaining recognition. At the foundation of the Massachusetts General Hospital here in Boston, nearly a century ago, provision was made for a certain number of house pupils, thus clearly recognizing the teaching function of the hospital. Well within the memory of most of us our hospitals awoke to the fact that trained nurses could not be had without schools in which training could be secured; hence followed the establishment in the hospitals of schools for the training of nurses.

The past thirty years has seen the gradual development of pathologic and bacteriologic laboratories in connection with our larger hospitals. The end sought, however, was the furnishing of aids to diagnosis to the attending staff, and only indirectly was any benefit to the patient involved. The careful preservation and indexing of case records so largely developed within the past few years may also be mentioned as rounding out the full stature of the ideal to date in hospital development.

At present, then, we find the modern hospital a highly specialized institution. It is fully equipped to treat all classes of patients, and neglects no means known to science to rapidly effect a cure and to return the patient to active life, able to cope with its problems. But is this enough? Has the hospital then discharged in full measure its duty to its patients? I believe not.

The world has been dominated for centuries by the theological idea that disease and injury are divinely appointed agencies. They are supposed to operate either as a punishment for man's sins or as a disciplinary measure to fit him to wear a crown and twang a harp in a better world. What, then, could the hospital do but receive the sufferer, mitigate to what extent it could the severity of his sentence, and discharge him with the injunction to return again when necessary. The introduction of vaccination against smallpox was not a little impeded in this country by thunders from hundreds of New England pulpits against such impious interference with the decrees of an offended God. We are just beginning to suspect that such ideas may not be entirely true. Any large city expends annually at the present time millions in combating disease, crime, and fire. How much is expended in prevention? Comparatively little. Yet a beginning has been made, and in that beginning lies the hope of better things.

More than twenty-five years ago the state of Massachusetts established the first sanatorium for consumptives, and in so doing has the honor of being the pioneer in the world-wide war against that disease. Incipient cases only were accepted for treatment. It was found, however, after years of experience that there was no diminution in the number of early cases applying for treatment. New cases of tuberculosis were constantly furnished by the contagion spread abroad by the late and chronic cases refused sanatorium treatment as unsuitable in that no hope of a cure could be entertained. An experience of three years in sanatorium work has convinced me that the most promising line of attack lies in the compulsory segregation of the ignorant and careless consumptive, and in the education and supervision of the intelligent consumptive, and in thus preventing infection of new subjects.

What is true in the case of tuberculosis may also be true in the case of many general systemic and local diseases. This field for investigation is a large one, and we turn with confidence to the hospitals of this country for its exploitation. Why should not the general and special hospital take part in a campaign for the prevention of all classes of diseases? You have the plant necessary. You have the cases in large numbers, and you have all the time between now and the end of the world. Institutions may and do survive for centuries, while the individual investigator has but a few years in which to work.

There are many lines along which the general hospital might work, and in so doing become an important factor in the great work of preventive medicine. Three suggest themselves for emphasis here, and in at least two of the three a tentative beginning has been made in many hospitals. I have in mind laboratory research, intensive study of carefully taken case records, and the education and reeducation of the patient.

As to the first of these, a little research work has been begun, in connection with routine ward work, by some of our hospitals for many years. This work, however, needs direction and intensification. This association might well take this matter up, and plan among its members a combined assault upon some problem in preventive medicine. At present too much desultory work is done which leads nowhere and is productive of results of no value. The general hospital has an opportunity in research work open to none other in the study of the rarer forms of disease, and this, too, should not be neglected. When the cause of a certain disease has been discovered and the pathology of the disease has been worked up, many investigators consider that problem solved, but in reality only a beginning has been made. A patient dead from pneumonia is little benefited by the knowledge that the pneumococcus has killed him by causing a purulent exudate into the air cells of his lungs. Let us go back of all that and try to discover the conditions under which the organism develops outside the body, in what manner it gains access to the body, and what conditions favor its development therein. Then, and only then, can measures be devised to protect ourselves from the attacks of this great destroyer.

Laboratory research work has furnished us with many unanswered questions. Among the most interesting of these are the variations in the action of disease-causing organisms in different cases. An answer to this problem may be found in some factor to be discovered in the life history of the patient.

Case histories, as at present taken in most of our hospitals, are practically worthless. They are taken by a junior member of the house staff in a hurried and perfunctory manner. There is no competent supervision of his work, and the case history often has no earthly relation to the diagnosis found at the head of the history sheet. Would it not be practicable to appoint a histographer on at least the staffs of the larger hospitals whose duty it should be to supervise all case rec-

ords? Proper instruction in history taking could be given the house staff, and assistance in filing and the making of references could be furnished the staff in the records room. A primary requisite for making these records available for study is that they be accessible, accurate, and aggregated in large numbers. Whenever a large number of histories of a certain disease become available, research workers could be detailed to study these records in search of the common factors having an apparent connection with the production of the disease in question or having a bearing on the treatment of the same. Many facts of important bearing on the etiology and incidence of disease doubtless lie buried in the records of our hospitals.

In 1894 Dr. R. F. Weir, of New York, performed at the New York Hospital the first operation for the relief of the condition known as surgical kidney. The patient recovered, and this hitherto fatal disease became amenable to treatment. A search of the autopsy records of the hospital made at that time by Dr. Weir's surgical staff showed a considerable number of cases of surgical kidney, which had come to autopsy in the preceding one hundred years, in which the condition was unilateral. These cases were operable. Had this been known, why should not this operation have been done many years earlier?

Recent investigations in the causation of beriberi have shown that the long-sought bacterial cause does not exist, but that the disease occurs in those who eat largely of polished rice. A rapid cure is effected in those suffering from this disease by injection of an extract made from rice polishings. Instances could be multiplied where the clew to the solution of problems in preventive medicine have been found in the case histories of a large number of patients of a given disease, and work along that line is most promising.

EDUCATION AND REEDUCATION OF THE PATIENT.

The hospital of late years has come to stand in the place of the family physician to many of its patients—that is to say, many of the beneficiaries have no family physician. The need, therefore, for the hospital to assume the functions of a family physician is apparent. This function cannot, for mere lack of time, be discharged by the attending physician or surgeon, who has or may have anywhere from 30 to 150 patients in his wards. It is a physical impossibility for him to discuss with each patient in his charge the factors having a causative influence in the production of the condition he is called on to treat. Why should not the hospital take up the education of its patients as a factor possibly of importance in preventive medicine? Many thousand persons pass annually a considerable time in our hospitals. Many of them are intensely interested in their conditions, and are lamentably ignorant of the fundamentals of right living. At present we treat, for example, cases of broken compensation in heart disease or an acute exacerbation in kidney disease. The patient is discharged "improved." We expect him to come back, and he does come back, often time and time again. Why should he not receive explicit instruction as to how to avoid a recurrence of his frequent breakdowns. Sanatoriums for the care of consumptives have made a beginning in this work. By means of printed matter, verbal instructions, and lectures to groups of patients we instruct them as to dangers of infection and reinfection, as to safe methods of the disposal of sputa and excreta, as to diet and mode of life, clothing, fresh air and exercise, and the many things which have been found to be of importance in the cure of consumption. Why should not this be taken up by our general hospitals and extended to cover many classes of disease?

In the last decade there has been an alarming increase in the incidence of the group of the so-called degenerative diseases of middle life. The expectation of life of a man of forty-five is actually less today than it was ten years ago, and this despite of the great advances made in the control of many diseases. The causative factors in the increase in degenerative diseases must be sought in the histories of a large series of such cases, and instructions formulated as to how the individual may escape the results of his own ignorance or folly. I know of no agency which can so well perform this service to the race as the general hospital. For many years it has been my custom to furnish certain intelligent medical cases on leaving the hospital with typewritten instructions as to diet, mode of life, etc., the observance of which might tend to prevent a recurrence of their illness. This procedure I believe to be of distinct value in cases of diabetes, Bright's disease, cirrhosis of the liver, and heart disease.

In any large hospital there may be observed any day a considerable number of patients on whose hands time seems to hang a bit heavily. Would it not be practicable to demonstrate to these in small groups something of the methods employed in the hospital for the prevention of the transfer of infection from one patient to another, for the disinfection of excreta, bedding, and dressings, the methods of preparing foods, of ventilation, etc. This could be supplemented by lectures on suitable hygienic topics and by printed matter bearing on the special disease from which the patient is suffering, and on the general requisites for a sane mind in a sound body.

The United States Public Health Service at present is printing for general distribution monographs on subjects connected with the health of the public. These are brief, worded so as to be understood by any reader, and are calculated to give the public definite information on a certain subject of importance in connection with health matters. These may be secured by application to the surgeon-general of the United States Public Health Service, Washington, D. C. The health boards of many states furnish printed matter of this nature for general distribution, and which may be obtained by institutions in the individual state. Thus it appears that printed matter is available from various sources. Sporadic attempts to educate the public have always been made. The story is told of Erasmus Darwin, grandfather of the great naturalist, that, having dined not wisely but too well, he was discovered a short time thereafter mounted upon an overturned tub in the market place of Nottingham, haranguing the public as follows: "Ye men of Nottingham, listen to me. Air becomes unwholesome in a few hours if the windows are shut. Open those of your sleeping rooms whenever you quit them to go to your workshops. Keep the windows of your workshops open whenever the weather is not unsupportably cold. I have no interest in giving you this advice." This was said in the eighteenth century, but it appears not to have as yet reached the major part of our population.

Preventive medicine may not be to our interest, but the welfare of our patients is and ever should be our paramount interest. I confidently believe, therefore, that the hospitals of this country will take an increasingly important part in the grand attack that is being made on the agencies, visible and invisible, which wage so relentless and unceasing a war upon the human race.

HOSPITAL WASTE AND ITS DISPOSAL IN SMALL INSTITUTIONS.

Description of Hackley Hospital—Central Incinerating Plant and Its Location—Personnel in Waste Technic—How the Work Is Done.

By MISS ELIZABETH A. GREENER,
SUPERINTENDENT OF HACKLEY HOSPITAL, MUSKEGON, MICH.

First of a Series of Papers on the Physical Management of a Small Hospital.

PAPER I.

THERE is probably no branch of work which presents more acute or more varied problems than those of the hospital world of today, representing in its breadth every variety of institution from the large, well-endowed hospital to the small, crudely organized, struggling country institution, whose very existence from day to day seems largely problematical.

The object of all hospital work, whether the institution be large or small, should be the relief and cure of the sick and suffering, the prevention of disease, and the promotion of medical science. Probably this is one of the very few statements which can be made concerning hospital work that offers little ground for argument.

Generally speaking, it is to the large hospitals of this country we must turn for traditions, standards, and general rulings on which to base the conduct of such institutions. Unfortunately, the requirements of most small hospitals are necessarily of such a different character that rules and regulations which would be of the utmost value in a large institution frequently cannot be applied at all in a small, isolated, country hospital. As a result, when the superintendent of a small institution undertakes to study conditions in other small hospitals with the idea of improving and standardizing the work of her own, she is apt to find that in most cases each institution appears to be a law unto itself, and the result of such investigation is more confusing than enlightening.

In attempting to give, in a series of short papers, some idea of the manner in which the routine or daily work is conducted in one of the smaller hospitals of the country, it is realized that in nearly every institution such work is regarded from a different standpoint, and that, in order to consider intelligently any plan for systematic work, we must take into consideration the character of the hospital itself, its location and surroundings, its construction, its endowment, or, unfortunately in most cases, its lack of endowment, its management, and the spirit in which it is regarded by the community or municipality which it serves. Quite frequently the success of the small hospital is dependent less on shrewd business management than on the creation of a

spirit of loyalty, interest, and good will among those people of the surrounding community on whom it must necessarily depend for its maintenance and support.

On one fact, however, concerning the administration of even a very small hospital all must be agreed, and that is that without a liberal endowment or proper municipal support the hospital is doomed to be a financial failure unless conducted on strict business lines, charging a fair and just financial equivalent to each individual for service rendered. No hospital board should feel justified in rolling up an annual deficit, trusting to the haphazard generosity of the general public through some local entertainment or tag day, which may or may not prove to be sufficiently successful, to meet the needs of the occasion. There certainly appears to be a tendency toward pauperizing a community when transactions which should be of plain business character are turned into public charities, and hospitals expected to make a mere nominal charge to corporations and municipalities for the care of their employees or dependents, thus relieving them of their just burden and throwing it on the shoulders of an already overtaxed institution.

One reads and hears so much of the struggle for existence on the part of the many small unendowed institutions, that a hospital which has the unusual advantage of having an adequate endowment for its use seems to shine out like a beacon of light on a dark way. Such an institution is the Hackley Hospital of Muskegon, Mich., one of the finest of the many monuments erected by the city's great and generous benefactor, Charles E. Hackley, who, after making a fortune in Muskegon, devoted the last sixteen years of his life to the improvement and development of his home city. During this time he spent over $4,000,000, as each of his benefactions was furnished with a liberal endowment. Hackley Hospital was the last institution he lived to build. By the terms of the gift it is placed under the guardianship of the First Congregational Church of Muskegon, which chooses its board of trustees.

The hospital cost over $250,000 to build, and has an endowment of $605,000. For an institution of its size, with a capacity of 75 beds, it is believed to be as complete, scientific, and modern in its plans and equipments as any hospital yet built. It is situated in the most beautiful part of the city, the site occupying four city blocks. The grounds, which have a growth of beautiful native oaks, have been improved and provided with paved walks and drives, shrubbery and flowering plants, making the environment of the hospital ideal in its beauty.

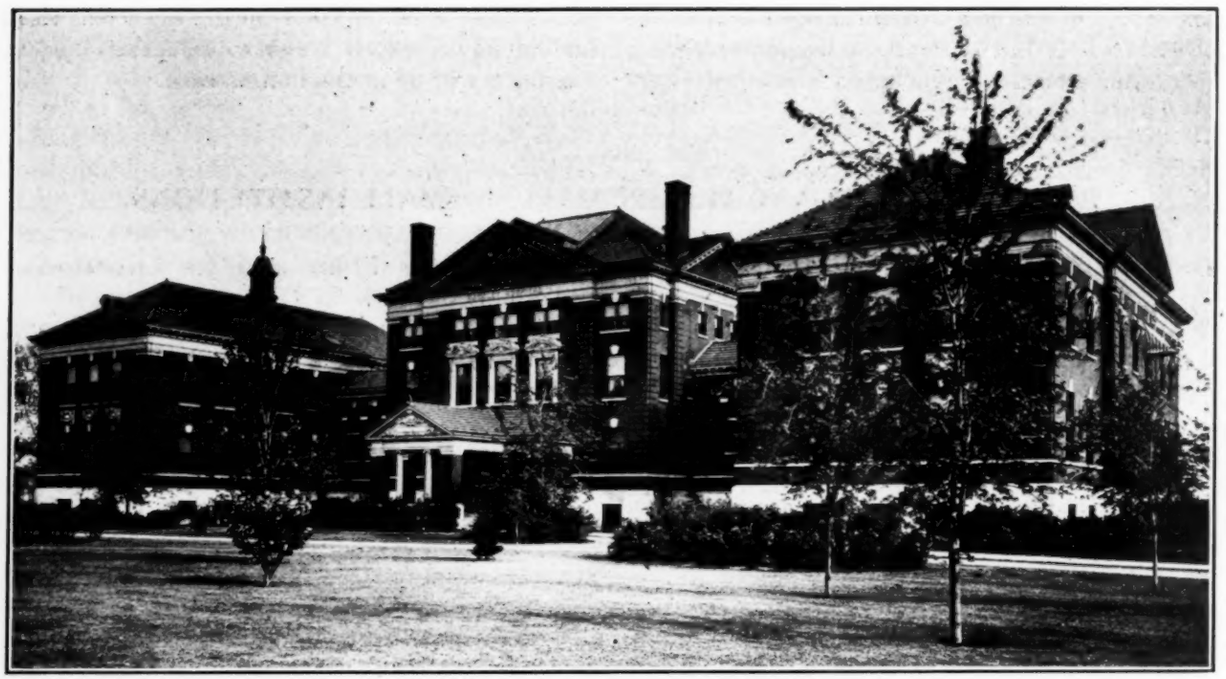


Fig. 1. Hackley Hospital—Front view.

The hospital is built on the pavilion plan, with a central administration building facing the north, while connected with this by spacious corridors are the east and west pavilions devoted to the wards and rooms for patients. To the rear of the administration building is the service building, with kitchen, laundry, and power, light-

ing, and heating plant. These four buildings are really one single building, constructed of the best material and practically fireproof. The extreme length from east to west across the front is 204 feet, while from the front of the building to the south end of the service building is 250 feet. The exterior walls are of red pressed brick, with foundations and stone trimmings of Bedford limestone. The roof is of red tile and the windows of plate glass.

The first floor of the administration building has a large well-lighted lobby in the center, on the walls of which are memorial tablets. Opening off from this lobby are the trustees' room, superintendent's office, reception room, pathological laboratories, doctors' room, and drug room. To the rear is the emergency operating or ambulance reception room. The second floor of the administration building contains the living rooms for the administrative officers.

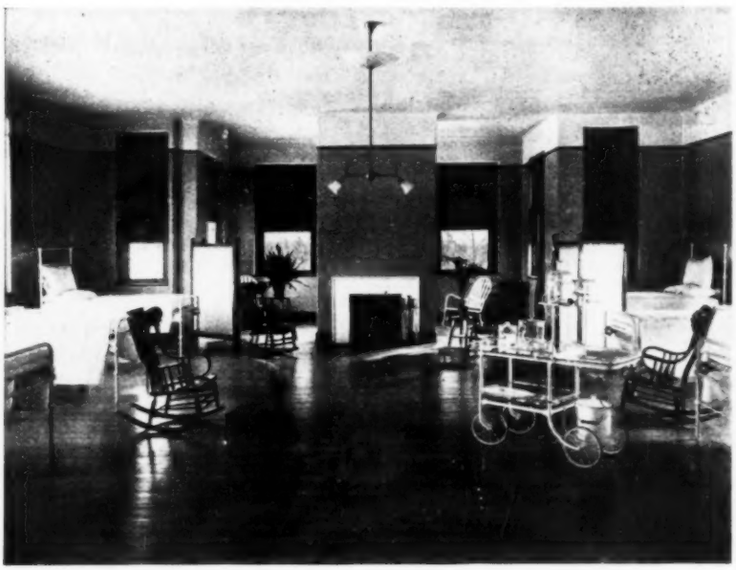


Fig. 2. Hackley Hospital—Women's surgical ward.

On the third floor is the main operating room, the septic operating room, surgeons' room, etherizing room, recovery room, nurses' room, and rooms for complete x-ray apparatus. The arrangement of these rooms is very convenient. The main operating room has an overhead northern light, believed to be as nearly perfect as can be secured.

The first floor of the west pavilion is arranged in rooms for private patients. The second floor contains the obstetrical department.

The east pavilion contains the men's medical and surgical wards on the first floor and a similar arrangement for women on the second floor. Between these wards on each floor are the diet kitchen, dining room for convalescing patients, and isolation room for a patient critically ill or unmanageable, bath and toilet rooms, and the nurses' charting room.

The service building is reached from the administration building through the basement corridor. Here are the dining rooms for the help, refrigerator rooms, diet kitchen, and bakery. The main kitchen is admirably lighted and ventilated, and has the best equipment of a modern institution kitchen.

There is an isolation department for contagious diseases, completely separated from the rest of the hospital, and a very complete hydrotherapeutic department, which is in the basement of the building.

The power plant is equipped with two 100-horsepower boilers and two direct connected units for furnishing power and operating the electric lights. The heating and ventilating system is a combination of direct radiation for furnishing the principal part of the heat and fans for ventilation. A large ventilating fan in the basement drives the warm air into every room in the building, while four attic fans draw the impure air away. The ventilating capacity is sufficient to give each patient fresh air at the rate of 30 cubic feet per minute. The air supply can be regulated according to the number of patients.

The hospital is furnished with everything to make the patients comfortable and for the best medical and surgical work. The charity work is constant, and gladly, but discriminatingly given. Including those who are given free bed service and those to whom part service is given, and the hospital extension work through the visiting nurse, it is safe to say that the charity work each year amounts to at least $5,000.

The difference between the income from hospital earnings and the outgo is met from the interest on the endowment of $605,000. It has been necessary at times to make additions and improvements to the property. It is the aim of the board of trustees to accumulate a surplus or reserve fund with which to meet extraordinary expenses of the future. Already the hospital is proving too small to meet the needs of the work, and it is hoped that in the near future we may be in a position to build a separate pavilion for obstetrical work, and a new nurses' home to replace the two private residences now used for that purpose.

The hospital is in charge of a board of trustees composed of nine laymen, who have absolute con-

trol of all hospital affairs. The medical staff is divided into eight departments. The chairman of each of these divisions, together with the chief of staff, form what is known as the staff committee, which meets generally twice a year with the board of trustees for special consideration of hospital matters.

The acting executive of the board is the superintendent of the hospital, who is also superintendent of the training school, as is commonly the case in smaller hospitals. There are also engaged as official assistants an assistant superintendent, a surgical supervisor, night superintendent, bookkeeper, and dietitian.

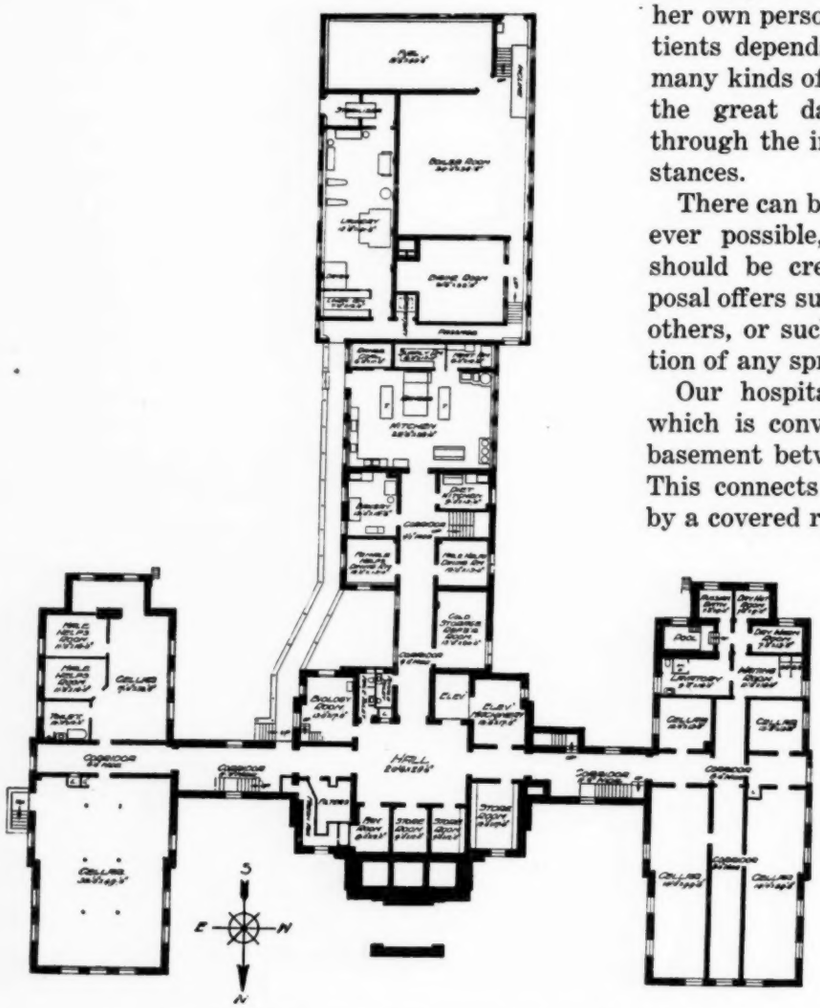


Fig. 3. Hackley Hospital—Plan of basement and service building.

WARD WASTE.

One of the really important points for consideration in every small hospital is the proper disposal of ward wastes, and another one of equal importance is the prevention of ward waste. Every small hospital has its own trials along this line, but one of the greatest elements in the solution of this problem from both sides of the question is in the training and developing of a personal sense of responsibility on the part of the nurses in training.

Every pupil nurse should be impressed, from the day that she enters the hospital, with the fact that a very large measure of her success in any line of nursing will depend on her own personal housekeeping ability and knowledge. She should also receive careful instruction in the difference between ordinary household routine and that of the hospital. It should be explained to her that her own personal safety as well as that of her patients depends largely on the care taken of the many kinds of ward waste. She should be taught the great danger of bacteriological infection through the improper disposal of any waste substances.

There can be absolutely no question that, whenever possible, all waste or refuse substances should be cremated. No other method of disposal offers such absolute safety and protection of others, or such radical measures for the prevention of any spread of disease germs.

Our hospital is provided with a crematory, which is conveniently placed in a recess of the basement between the engine room and laundry. This connects with the main basement corridor by a covered runway, so that garbage or dressing pails with their contents can be taken there on a small truck provided for that purpose without coming in contact with other parts of the building. This outdoor passage is also used in taking soiled clothing from the clothes chutes to the laundry, or in carrying articles to the sterilizing room in the basement for disinfection.

Each morning a fire is started in this incinerator and kept up during the day. It is the work of one orderly to collect all dressings or garbage cans twice daily from the wards and take them to the crematory, where the contents are inspected and burned, after which the cans are scrubbed and scalded in a special hopper provided for that purpose and returned to the wards. This work is in charge of one person, whose special duty it is to see that no articles of value are accidentally destroyed. Each can is plainly marked with the number of the ward, and each ward has one dressing can, which is kept in the bath room, and one smaller garbage can, which remains in the diet kitchen. Any article of value inadvertently

thrown into these cans is taken out, placed in a paper bag and marked with the number of the ward from which it came, and turned over to the supervising nurse, who places the blame for such carelessness where it belongs. In the average small hospital there is, of course, less opportunity for occurrences of this kind than in larger institutions, where the waste accumulates in much larger amounts and where the number of workers is greater, and as a consequence harder to supervise closely.

All refuse from the wards, whether in dressing or garbage cans, is burned. All the food from the serving rooms or diet kitchen is placed in a covered receptacle provided for that purpose, and returned to the kitchen after each meal. By waste food is meant that returned uneaten from patients' trays, or from the various serving rooms, which for any reason it is undesirable to use again. In the kitchen the food from these containers is emptied into what we call the clean garbage cans. We are always able to make satisfactory arrangements with some of the farmers in the vicinity who are glad to pay a small amount weekly for this clean garbage for their pigs and poultry. This is called for and removed daily by the farmer between 4 and 5 o'clock in the afternoon, by which time most of the refuse for the day is collected. All undesirable refuse from the kitchen is placed in what we call the refuse can and burned twice daily.

Broken glasses, dishes, etc., which need to be replaced are put in a box kept for that purpose and sent to the store room for exchange every Thursday morning. This exchange is made by the assistant superintendent, who demands a strict accounting from each head pupil nurse regarding such breakage. The broken articles are then removed in a basket to an out-door bin kept for that purpose, and when sufficient have been collected are conveyed to the city dumping grounds. Any empty cans, broken bottles, or articles which cannot be burned are collected each morning and sent to this bin.

The ceilings and walls of the service rooms and wards throughout the building are brushed down with soft wall brushes every week. These brushes are then soaked in a disinfectant solution, after which they are washed in hot suds and dried. The dusting throughout the hospital is done with soft cloths wrung out of a weak disinfectant solution. Window sills, moldings, etc., are also treated in this manner. These dusters are washed daily in hot suds, and sent to the laundry and boiled once weekly. The ward floors are scrubbed and waxed every other week. Twice daily the floors are brushed with a soft hair broom and then gone over with a plain broom furnished with a soft, thick cover, dampened with a weak disinfectant solution. These covers are cared for in the same manner as the dusters.

Our ward ice boxes are emptied and scrubbed thoroughly every morning, and at this time a solution of hot sal soda is run through the drain pipes to clear them from any grease or waste substances. All drains from sinks, hoppers, etc., are also flushed at least once daily with a hot soda solution.

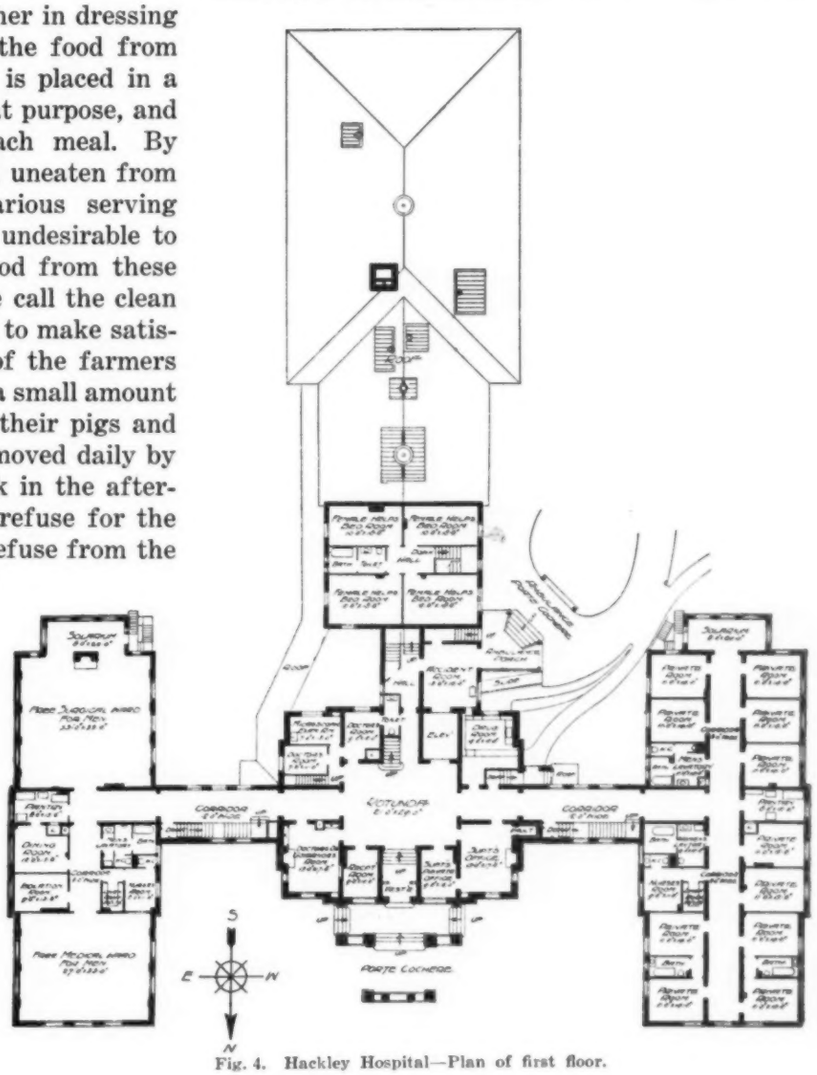


Fig. 4. Hackley Hospital—Plan of first floor.

As the hospital is provided with clothes chutes, no soiled linen is ever allowed to accumulate in the wards or bath rooms, except that which is in the process of disinfection. Any infected or badly soiled linen is cared for in the wards and then taken immediately to the laundry in large foot tubs by the orderly.

Mattresses, pillows, etc., requiring special disinfection are pinned in large square ticking covers and sent to the sterilizing chamber in the basement, where they are sterilized by steam.

A locker room in the basement of the hospital does away with the necessity of keeping in the ward any clothing belonging to patients. The institution furnishes Turkish bath robes and slippers for patients requiring these articles, so that we have very little annoyance or trouble on the score of patients' clothing.

The subject of the disposal of surgical material from ward dressings, etc., will be considered in the next paper.

HOSPITAL ATTITUDE CONCERNING PUBLICITY THROUGH THE NEWSPAPERS.

Newspapers, as People's Agents, Deeply Interested in Hospitals and Their Work, and Have Right to Legitimate News—How Superintendents Should Meet Reporters.

By MR. NORMAN MAUL, New York.

WHAT should be the attitude of the hospital toward the press? Should it hide behind a veil of mystery, or should it be willing to give its news to the papers? Should it welcome reporters, or should it treat them as troublesome inquisitors?

These are pertinent questions when it is remembered that in the eyes of newspaper editors every hospital is a news source, and is therefore subject to frequent calls from newspaper writers. The fact also that the hospital name appears in the police report of every accident or other emergency call to which its ambulance has been sent should not be forgotten, and that many of these police reports are, speaking from a news viewpoint, incomplete, makes it all the more incumbent on the hospital to give serious thought as to its publicity policy, for the reporter, in "digging" for his additional facts, must call on the hospital superintendent or the abmulance surgeon.

Every street accident, every riot, every murder, every shooting affray, and even the cases of ordinary sickness, are reported by the police and posted on the bulletin board, together with the name of the hospital, the ambulance surgeon, the diagnosis, and the final disposition. With these reports as leads, the reporters seek the additional details of the various "stories," and the trail frequently leads to the hospital. It is a wise institution that elects a liberal publicity policy.

Lest it be thought, however, that such a policy will involve the hospital and its medical staff in ethical violations, it should be remembered that there are scores of hospital incidents and bits of information that may be given to the papers without betraying the confidence of patients or suggesting advertising on the part of physicians. These are the two great fears that apparently underlie the seeming unwillingness of certain hospitals to let the public know what they are doing.

Granted a hospital is to pursue a liberal policy toward the papers, what should be the first step? The answer is simple enough: let the fact be evidenced through the attitude of the hospital officials who come in personal contact with the representatives of the papers—the superintendent in his office and the intern on the ambulance.

In addition to the police incidents, there are many little happenings in the day's routine of a hospital that make good news. The stories of certain operations are always good, and they can be made public in such a way that the privacy of the patient is not trespassed, it being seldom necessary to use the name of the operating surgeon. The technical aspect of the operation alone will cover many stories, especially if it has to do with some great advance in surgery, and can be told in such a way as to come within the understanding of the lay mind. Better than such stories, however, are those which possess the human interest element. The sacrifice of school children who give their skin that a burned playmate may be saved is of strong interest, and it never grows old. This may also be said of the friend or relative who gives a quantity of blood that a weakened patient may gain strength. Then there are the witty sayings of the tots in the children's ward, which, while not news, are appreciated for the childish humor they portray, as in the case of the three-year-old boy who, on seeing the stethoscope used for the first time, asked the doctor to telephone to his stomach to find out if he was hungry.

There is also the social life of the hospital—the dances and class exercises of the nurses, the interns' dinner to the doctor who is finishing his service, sometimes a romance, and always the Thanksgiving and Christmas exercises that are held for the ward patients. All these little events make good news items, especially in the smaller cities. They could easily be picked up during the day and made ready for the reporter's call. Such

an interest, while it may take a bit of valuable time, will go a long way toward establishing a bond of friendship. Such a friendship is well worth having, for there are other hospital stories that might be far better if left untold.

In a certain hospital in a large city a fever patient managed to get out of bed, pass through a ward door, and down two flights of stairs before he was missed. He was easily traced to the court yard, where he was found roaming about in his pajamas. There was no stir, and, except the nurses and orderlies and the wakeful patients, no one knew about the incident until it was reported to the superintendent the next morning. Through some roundabout way, however, the incident reached a newspaper reporter, who, seeing possibilities for a good story, went to the hospital for further information. He was told that no such thing had happened—it was none of his business anyway, and, figuratively speaking, was "kicked out."

That afternoon his paper told of a terrific struggle between a delirious patient and a nurse, of the escape from the institution after a leap through a window pane, and of the chase through the streets before the man was caught. The story was taken up by other papers, the hospital besieged by reporters, and the matter came to a climax three days later when the man died and the coroner held an inquest.

A different attitude on the part of the superintendent would have prevented the first story, with its gross exaggerations. The incident would have been forgotten the next day, and it is doubtful if even the coroner's hearing would have received more than passing mention. As it was, the coroner's jury censured the institution for the laxity of its methods, and the fact was duly recorded in glaring type.

Such stories get out through what is known as a "tip." A tip may come from almost any source, taking the most roundabout way of finally reaching the newspaper office. A policeman might be on duty at a hospital, and it would be but natural for him to tell his reporter friends the things he saw. Or a patient might have friends in newspaper work, or even the hospital employees might not be unwilling to speak of some of the things they see. It is impossible to enumerate all the different ways in which a "tip" might get out, and there is one thing certain—no reporter will ever divulge the source of his information; to do so would be to violate the most sacred ethic of his profession.

Once a tip is out, even though it reflects some discredit on the hospital, the superintendent must make the most of a bad situation—smile, if he can, through the reporter's cross-examination and do what he can to help. In other words, if he is a "good scout," the story will not appear any worse than the facts make it. If he sends out word that he has nothing to say and shuts the door in the reporter's face, a highly imaginative yarn will be printed and no amount of second-day explanation and denial will ever counteract the first day's story.

Take the case of the hospital where the interns petitioned the management for better meals. The tip got out through one of the maids who knew the wife of a printer, who in turn told his city editor, who sent a reporter to cover the story. The reporter went direct to the superintendent, who admitted that such a petition had been presented, but said there were absolutely no grounds for complaint.

"Come and have dinner with us now," the superintendent said; "you'll see for yourself just what our meals consist of."

The invitation was accepted, and the dinner proved to be good and substantial, even though lacking in fancy adornments. Not a word was printed about the incident, and the reporter and superintendent became fast friends.

On another occasion a reporter from a paper that went to press at 1 a. m. telephoned a hospital at 10 o'clock at night to learn the condition of a patient who had been seriously injured in an accident that had attracted country-wide attention. Granted that 10 o'clock is quite late, as hospital hours go; it was very early in the evening from a newspaper standpoint. The house physician answered the 'phone, and, when he learned what was wanted, snapped back that it was too late an hour to get such information, and advised the questioner to call at 9 o'clock the next morning. At 9 the next morning the paper that wanted the information had been on the street for several hours, and the information was absolutely useless. There is no tomorrow in newspaper work—if the news cannot be had today, it is dead. Perhaps nothing ever came as a result of that intern's brusk dismissal of the question, except that an opportunity to establish cordial feeling between a hospital and a paper was lost.

Three years ago a man unfamiliar with newspaper ways took charge of a city institution, and on the first day at his new desk met the reporter who covered the district for an afternoon paper. Their conversation soon took an intimate turn, for the superintendent had never before been connected with hospital work. He wanted to know if it was a common practice for reporters to call at the institution, and, being assured that it was, wanted to know what kind of stories would be de-

sired and what his general attitude should be. The reply was: "Be frank; tell what you know and don't attempt to beg or bribe the reporter to hold anything out. Even if a nasty story has cropped up and the reporter seems fresh, hold your temper. Remember also that very few papers desire to discredit any public institution. They want the news as they see it, and they'll always give the proper authorities the opportunity to make the first statement."

Perhaps the reader will ask why a hospital ought to think about publicity and ways of meeting the newspapers. Of course the institution can go on its way healing the sick and caring for the injured with little concern about what outsiders think of the work, yet it is nevertheless true that the public is vitally interested in its hospitals and institutions, and vitally interested also in the progress that surgeons are making in their research laboratories.

And, after all, the hospitals exist solely for the public, and are supported either directly or indirectly by the public. Therefore publicity to a certain extent seems fitting.

NEW NURSES' HOME AT THE MASSACHUSETTS GENERAL HOSPITAL.

Four-Story Addition Planned to Give Pupil Nurses a Proper Home Life—Individual Rooms, Plenty of Baths, Recreation Rooms, Outdoor Porches, and Parlors.

By FREDERIC A. WASHBURN, M. D., Administrator.

THE Massachusetts General Hospital has recently erected an additional home for nurses. The Thayer Building, now on the hospital grounds, contains provision for 113 women. For several years it has been impossible to accommodate all the hospital nurses in this building, and it became necessary to erect the newer structure. It is across the street from the hospital grounds, connected by a tunnel, which will later enter the basement of the administration building which the hospital hopes to erect soon.

The plans which accompany this article are so plain that description is almost unnecessary. The building faces north, and occupies the whole of a small city block. It will be seen that the lavatories and toilet rooms are on the north side, and the bedrooms extend around the east, south, and west sides, thus insuring entrance of sunlight into

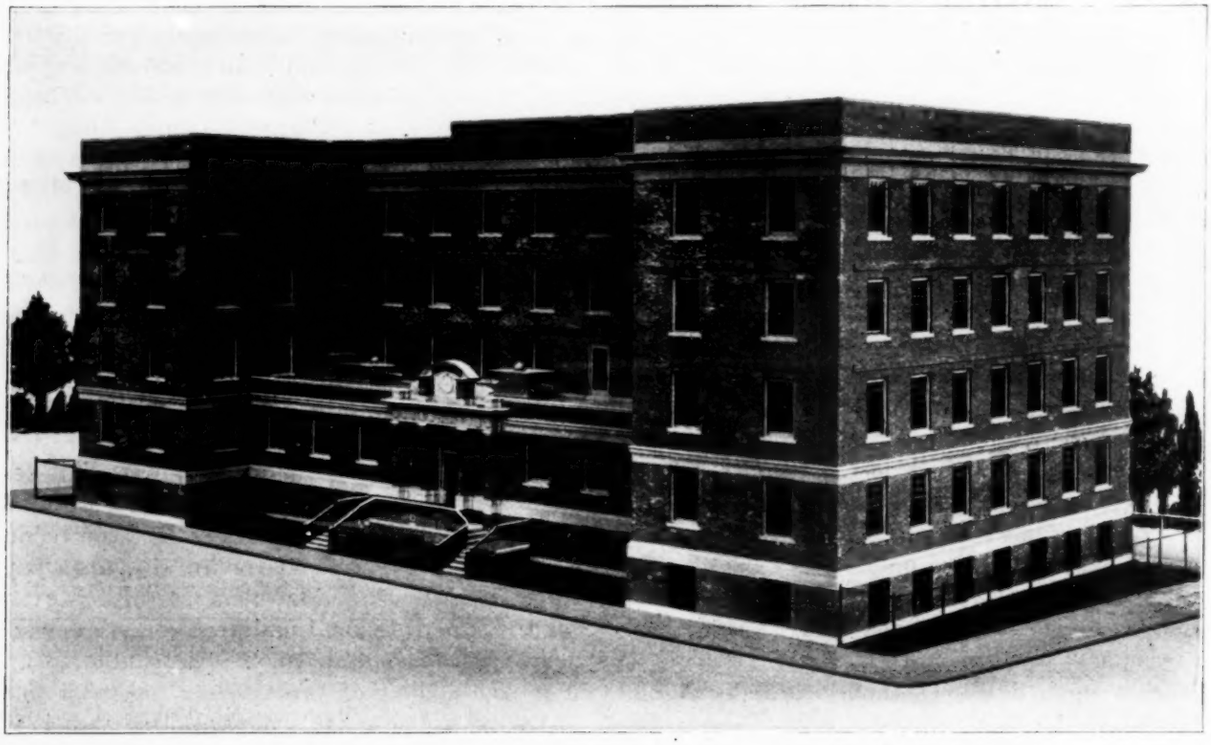


Fig. 1. Nurses' Home at Massachusetts General Hospital—Front and side view.

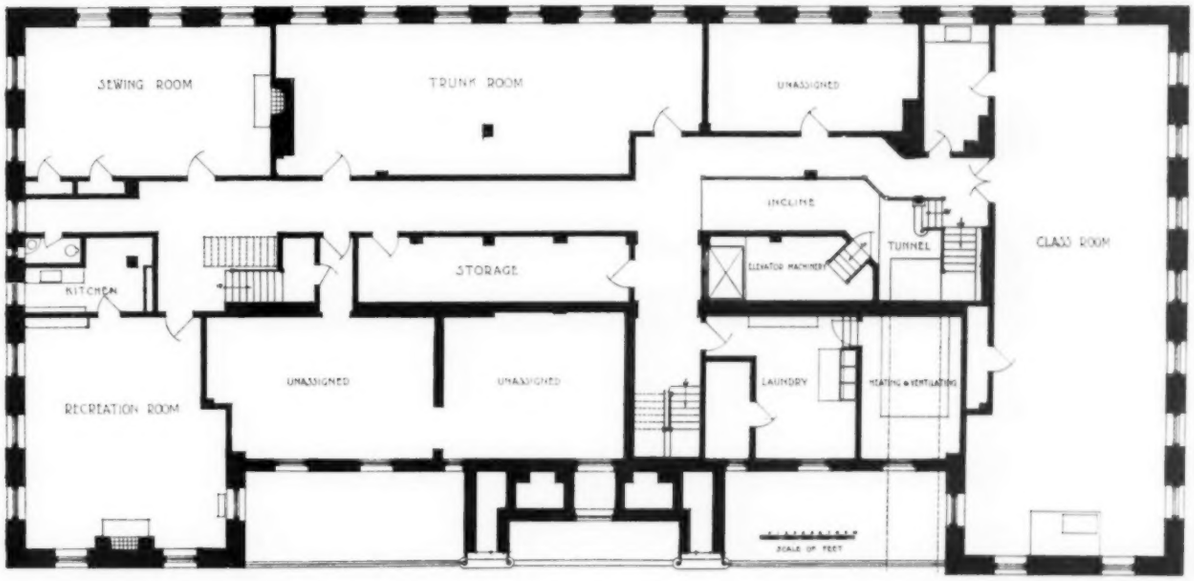


Fig. 2. Nurses' Home at Massachusetts General Hospital—Plan of basement floor.

each bedroom at some time in the course of the day.

There are open-air sitting rooms upon the roof, part of which is covered by an awning, and on the one-story porch in front. There are 101 bed rooms in the building, and two suites of bed room, sitting room, and bath for the superintendent of nurses and the dietitian. There is a guest chamber, with bath adjacent. One of the nurse instructors has a study beside her bed room.

The supervisors have separate bathing facilities from the pupil nurses and a sitting room for their own use. There are two small sitting rooms on each floor. The first floor has a large living room, in which the nurses may entertain their friends and have dances and small entertainments. This room will be handsomely furnished.

In the basement is a recreation room, with a small kitchen opening from it equipped with a gas range. This room has an open fireplace. The other rooms in the basement are a large class room, trunk room, small laundry, and sewing room. There is an electric elevator operated by push buttons. The building is fireproof throughout. The floors are made of reinforced concrete, with German battleship linoleum cemented to the surface. The only exceptions to this finish are that in the large living room is a quartered oak floor, in the vestibule Italian marble, and in the toilet and bath rooms terrazzo.

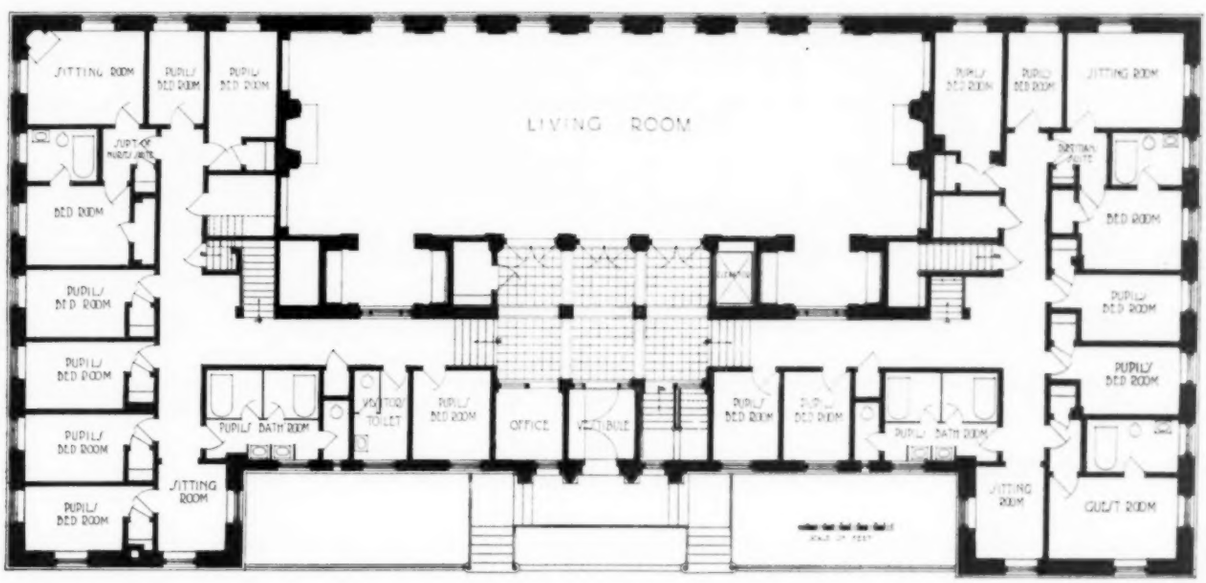


Fig. 3. Nurses' Home at Massachusetts General Hospital—Plan of first floor.

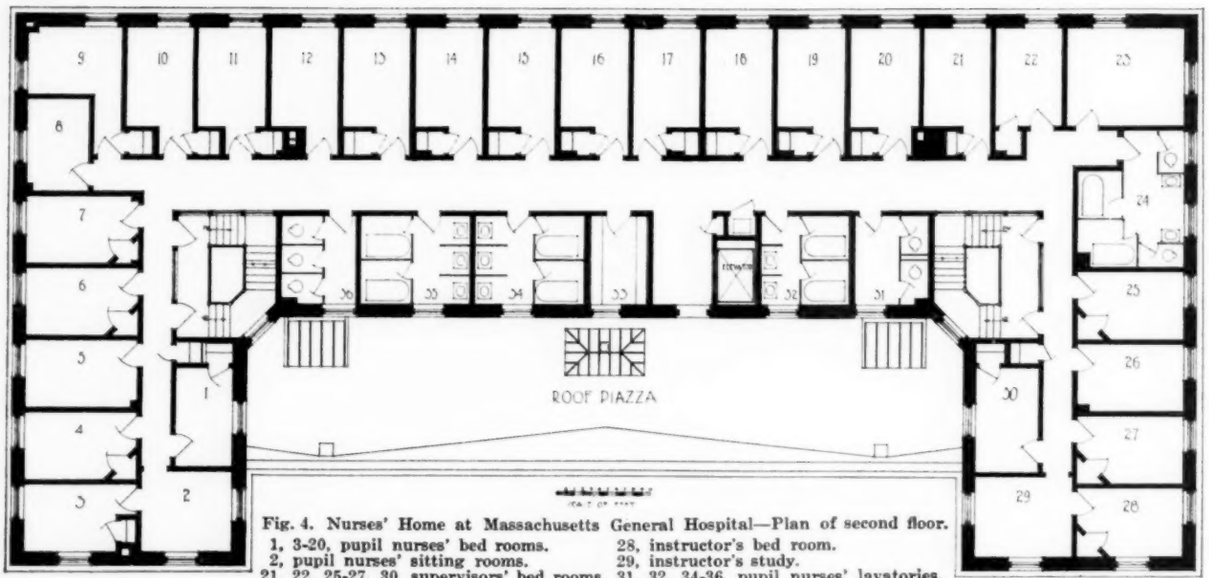


Fig. 4. Nurses' Home at Massachusetts General Hospital—Plan of second floor.

1, 3-20, pupil nurses' bed rooms.
2, pupil nurses' sitting rooms.
21, 22, 25-27, 30, supervisors' bed rooms.
23, supervisors' sitting room.
24, supervisors' bath room.
28, instructor's bed room.
29, instructor's study.
31, 32, 34-36, pupil nurses' lavatories.
33, linen room.

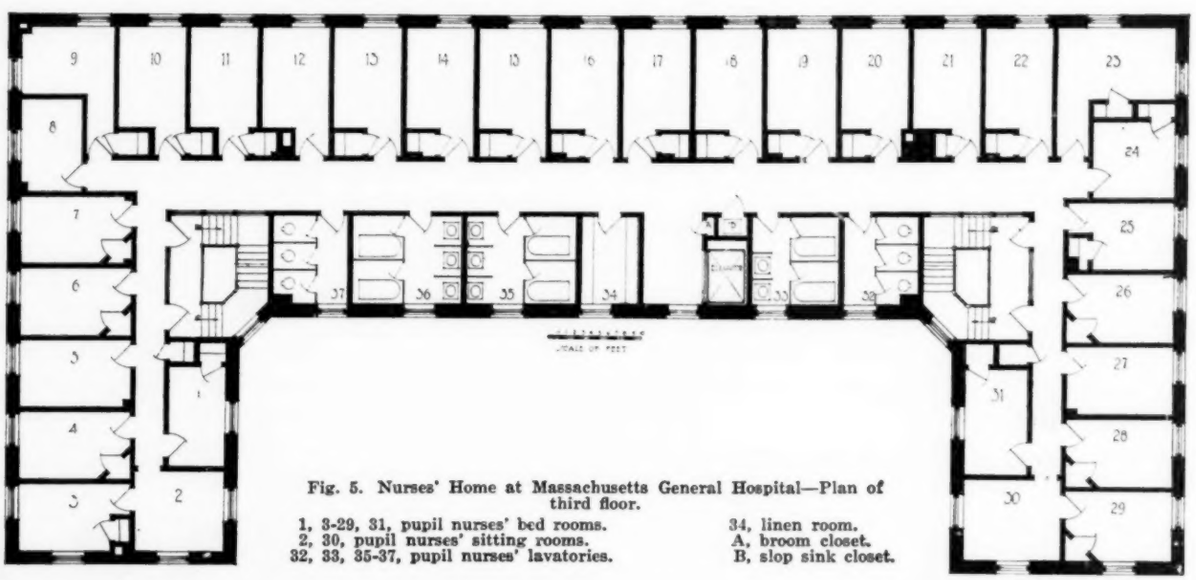


Fig. 5. Nurses' Home at Massachusetts General Hospital—Plan of third floor.

1, 3-29, 31, pupil nurses' bed rooms.
2, 30, pupil nurses' sitting rooms.
32, 33, 35-37, pupil nurses' lavatories.
34, linen room.
A, broom closet.
B, slop sink closet.

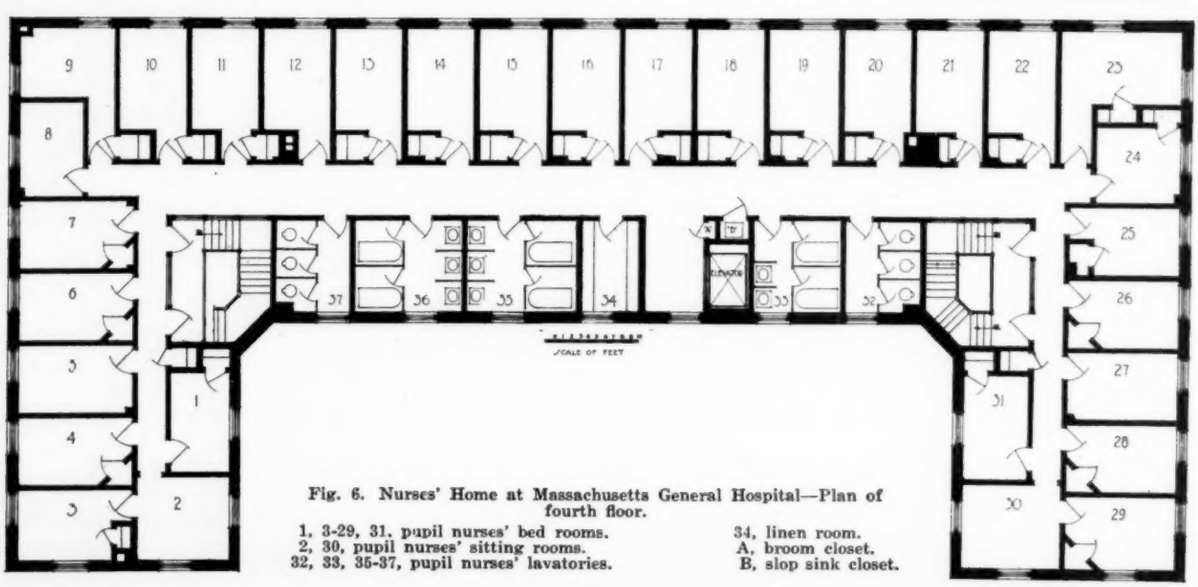


Fig. 6. Nurses' Home at Massachusetts General Hospital—Plan of fourth floor.

1, 3-29, 31, pupil nurses' bed rooms.
2, 30, pupil nurses' sitting rooms.
32, 33, 35-37, pupil nurses' lavatories.
34, linen room.
A, broom closet.
B, slop sink closet.

The building is designed, structurally, to receive an additional story at some future time. To provide for this, the fifth floor slab has been laid. The present roof is of light steel and cinder concrete construction, strutted up from this fifth floor concrete slab. Everything is so arranged that the fifth story can be added without making any change below this floor slab.

The principle is recognized that, to attract to our training school the women we want, we must make the living conditions attractive, and this we have tried to accomplish.

LARGE PART OF HOSPITAL WORK PERFORMED IN THE HOME.[1]

The Relation of Hospital Efficency to the Efficient Organization for Home Nursing—Few Patients Treated in Hospitals.

By RICHARDS M. BRADLEY, Boston.
TRUSTEE OF THE THOMAS THOMPSON TRUST.

A MARKED feature of our time is the broader and clearer view that we are getting of the facts with which we have to deal in our community life.

As one result of this, we are beginning to realize that we must work out a properly adjusted general plan for the handling of the *whole* problem of sickness, whether in or out of our hospitals. In consequence the hospitals are feeling the call that they shall bear a more clearly defined part in this general scheme, partly by doing some of the needed outside work themselves and partly by adjusting their relations to other organizations that have that work in hand.

We are passing the pioneer stage in the problem of handling sickness, when each separate unit had to develop its own individual efficiency, and we are now measuring the efficiency of each unit not alone by its own individual accomplishments, but also by its power of relating its work harmoniously and effectively to the work of other units in the same field. The strong man in the boat must not only be able to put strength into his own oar, but he must also properly adjust that strength to the forces of the other men in the boat. If he does not keep time with the other men, his efficiency is at a discount. We are thus coming to test the efficiency of the hospital in part by its ability to help in the coordination of all forces for the care of the sick.

We are also beginning to realize that these outside forces, if properly handled and organized, can be made a most important factor in forwarding the hospital's own particular work, and for that end alone the proper organization of these forces is worth the best attention of the hospital head.

It has perhaps been exceptionally hard for those who are giving their life's work to the hospital to fully realize this relation of their own work to the general field of related work, or to take hold of the idea that this outside work, scattered as it is, is a proper subject for a studied and comprehensive system of organization.

Everyone who is engaged in effective and absorbing work of his own must sometimes find himself forgetting the great general field of which that work is only a part, and there is double danger of this with the hospital. Hospital work is absorbing, concentrated, and closely organized, while the kindred outside work for the sick has been scattered, unorganized, and consequently as a work hidden from the general view. It is, therefore, difficult to keep in mind its size and importance.

And yet the magnitude of this outside work, when its scattered units are taken into account, is simply bewildering. A recent estimate puts it as ten to one of institutional work. Recent careful canvasses in New York state, covering a population of 17,000, embracing varieties of locations from the east side of Manhattan to hill townships of scattered farmhouses in Dutchess County, show a ratio of 13.4 percent of cases of sickness receiving hospital care as against 86.6 percent cared for at home. The ratio of home cases is undoubtedly far larger in the country at large.

We know that there will be upwards of 1,500,000 cases of mortal illness within a year in the United States and Canada, and most of us expect, when our time comes, to die at home. There will be more than 2,000,000 confinement cases, and most of us were born at home and expect to have our children born there. When in addition to births and deaths we consider the innumerable other cases, part of our daily knowledge, of severe illness needing service outside of the hospitals, we get an added realization of the vastness of this problem of the proper care of sickness in the home.

A few years ago I became impressed not only

[1]Paper read before the American Hospital Association at Boston, August 26, 1913.

with the amount of work that must necessarily be done, in dealing with sickness, outside of the hospital proper and within the homes, but also with the amazing lack of effective organization needed to accomplish that work with any degree of efficiency and economy.

I was not alone in having this impression, for at least one responsible observer has deliberately declared that the net result up to date of organized and scientific care for the sick has been to leave the average family of moderate means, in case of sickness in the home, worse off as to assistance other than medical service than it was a generation ago. The well-to-do get the benefit of the scientifically trained nurse, and a part of the population have visiting nurses; but the great bulk of the people are, as regards home care, worse off than a generation ago. This is apparently largely due to lack of organization.

Within the hospital we seem to have everything that organization can do in the way of nursing and care; outside of the hospital conditions are reversed. There is one notable exception—namely, the visiting nurse work. This work, however, is, unhappily, largely identified with the poorer classes, and, at best, meets the needs of only a limited portion of the home cases—those in which there is somebody available to give continuous care to home and patient.

I am not able to give you here more than a brief outline of an attempt that has been made to fill these gaps, and to work out a comprehensive system for dealing with sickness in the home.

The work has started in Brattleboro, Vermont, a manufacturing town of some 8,000 people and a center for a farming district; the bulk of its population was neither very rich nor very poor, but was pervaded with a strong spirit of personal independence. Their financial and domestic conditions were those of at least five-sixths of the people of the United States and Canada, and their problem was the problem of all other communities. Hospital and visiting nurse services were provided, which did well so far as they went, but served likewise to demonstrate conclusively that a large number of the needs in sickness could not be supplied by such means.

The work of developing a more complete system began, and has continued by taking the case of each family where there is sickness, finding out the exact conditions and needs caused by that sickness in the household, and studying to supply the necessary service in the best way at the least cost, whatever those needs might be.

To do this it was necessary to have a headquarters open night and day, with a capable person always on hand to take the calls, and then to organize forces in accordance with the needs thus developed.

Now, what are those needs?

Dr. Richard Cabot and his coworkers have shown us that the patient in the hospital ward or dispensary is not an isolated unit nor a one-dimension proposition; and that, in order to be treated successfully, each case must be considered in relation to the patient's individual circumstances, and must be considered in several aspects besides the purely medical or surgical aspect.

It is hardly necessary to say that the housewife and mother of young children, confined to her bed by either illness or childbirth, is equally far from being a one-dimension proposition or an isolated unit, and that precisely the same principles apply to the treatment of her case, and to many other cases of sickness in the home.

Whether the need be for a highly trained nurse or for a good plain cook and children's caretaker, or for both, depends on the circumstances of the individual case, and not on any foreordained rules. Moreover, there is no question that the cook or caretaker may, under certain circumstances, be a more important therapeutic agent than the most highly trained nurse. It is difficult to cure any woman whose household is going to pieces under her eyes, and her actual needs and those of her household must be seen, acknowledged, and met.

After work done for a number of years on these lines—work that is still in the experimental stage—the following organization has been evolved:

The headquarters are open day and night to the call of physicians and of families in difficulty through sickness, the usual rules being observed as to relations with physicians in nursing cases.

The working force is as follows:

Under the general superintendent is a visiting nurse, doing the usual visiting work, but interchanging and coordinating her work with a supervising graduate nurse.

This supervising nurse has under her a salaried body of nongraduate workers, who work under supervision and direction, doing such nursing work as they are directed and instructed to do by the supervisor, and also such household service as is entailed by the sickness.

In addition to this force there is a directory and employment agency for graduate nurses at one end of the list, and at the other a miscellaneous list of all the people in the town who can go out and help by the hour, day, or week. The association does all of its work on a business basis, doing work, where necessary, for charitable organization and individuals, but not dispensing charitable aid itself either in remission of charges or in money.

It is intended by thus organizing to have a capable head in touch with all the forces needed in a household when sickness comes, who can use those forces in the most effective way. In using these forces together, we come naturally to deal with the coordination of labor in nursing, a thing which, owing to the newness of trained nursing in the world, has hitherto been strangely lacking in this country. We have had competition where we needed coordination.

The ordinary confinement case can perhaps best show the advantage of the coordination of graduate with nongraduate service.

When the labor begins, we call in the supervising nurse, a graduate thoroughly trained in maternity work, and with the experience of dozens of cases in the course of the year. When she has completed caring for the mother and baby during and after the birth, she leaves an assistant in the house, whose business it is to continue the care of the mother and child under this supervisor's directions, and likewise to help with the meals and with the care of the other children. Where the work is very heavy, a third woman may be needed for an hour or two during the first few days. The case is then carried through the succeeding days by means of regular visits by the supervising nurse, who directs the assistant and gives the case such skilled work and observation as the conditions call for.

As before stated, I can here indicate only the general nature of this work, but can give details later to anyone who may be interested.

Whether a local unit in this exact form is adapted to larger towns is a matter for experiment to show. What I am sure of is that work in the homes can be fully organized along these or similar lines, and that the cooperation, counsel, and assistance of the hospital, which trains women for service in the homes, is needed in order that the hospital may render to the community full measure of efficient service.

So much for the outside organized work in the homes of the people and the relation of the hospital to it.

Now, as to the effect of developing and perfecting this outside organization in making the hospital's own main work, within its own walls, more satisfactory and efficient.

It is, in the first place, of the greatest importance that the hospital should get the right patients at the right time. As to getting the right patients, you are all aware that you need vastly more money for hospital construction and management than you have or are likely to get in order to give accommodation and service to those patients for whom the hospital is the only proper place. If, then, you have at your command another plant that, if properly utilized, can properly serve those who do *not* need to be in the hospital, but are now crowded into the hospitals to the exclusion of cases that do need your especial facilities, it is an economic waste and a failure in the test of efficiency not to endeavor to make effective use of that plant.

The plant that I refer to is, of course, the home, and in the aggregate it is a far greater plant, and has far greater resources of both money and service than the hospital. It must, however, be used efficiently, and its efficient use has thus a direct bearing on your own effectiveness.

There is another reason why you do not always get the right patient. Without proper organization for the care of the home in emergency, the patient often cannot be spared from the home, or is not spared in time to be helped by the hospital. Here also is an instance of the direct bearing of home care organization on your own effectiveness in doing your own appointed work.

Again, there is no need for me to tell you that timeliness in going to the hospital means much in producing the maximum of benefit from the hospital's services. I need not tell you how greatly this timeliness is facilitated by those outposts in the community, the visiting nurse organizations, for you know it.

What we must not forget is that it is only the edge of a far larger field that is now touched by these visiting nurses, and that the great bulk of cases in the home is still practically out of touch with the scientifically trained nurse.

This same touch by the skilled graduate nurse of the right kind on the wider field that must be occupied by the organizations giving general service in sickness will necessarily produce the same result—namely, getting hold of more cases that need to go to the hospital, and getting hold of more cases in time.

Next, when we have the patient in the hospital and have done for that patient what the hospital can best do, the output of the hospital often does not represent a completed job. The hospital's output is a man or woman who has just passed through a mortal crisis and is usually physically unfit for the stress of every-day life.

Unless the hospital can content itself in many such cases with the empty name of service, or unless an enormously expensive system of convalescent homes is provided (which, by the way, would by no means relieve the patient's solicitude for the home during absence), we must again have recourse to making efficient use of the home; if we do not, the hospital must either retain the patient too long, to the exclusion of other patients,

or must turn the patient out with the certainty that there will be a loss of the whole or a large part of the benefit given by the hospital at so great a cost of skill, service, and money.

You cannot get the full efficiency out of your hospitals unless by organizing you get the full efficiency out of your homes.

It is an economic paradox to say that there is no money available to save the spending of far more money. As a business proposition, organized work for the sick in the homes must be made to cover the whole population if the hospitals are to find room for the cases that should be within their walls, and are to properly dispose of those cases that should not be there.

Outside organization has its bearing on another field of hospital efficiency—namely, the educational part of its work, the training of women for the care of the sick.

The use of coordination of labor by organizations of this kind will afford to the hospitals an opportunity to give a different bent to the minds of those whom they train, and to bring about a change in the present abnormal and unsatisfactory position of the graduate nurse.

We appear to have something like 100,000 women doing nursing for a living in Canada and the United States, of whom perhaps 10,000 are graduates of our hospital training schools. What would we think of a West Point or an Annapolis whose graduates had no working relations with the private soldiers, seamen, corporals, sergeants, and warrant officers of our army and navy? What would we think of a technological institute whose graduates could not build a bridge or a ship except in association with holders of a diploma? It is hardly an exaggeration to say that by our lack of organization in home work we have put most of our graduate nurses into a parallel position.

By organizing we make officers of our trained and educated workers in almost every other line of activity, and thus make their skill and education count to the uttermost. Why do we not do the same for our hospital graduates? Instead of this, we are making of most of our graduates a body of women with a position so anomalous that both we and they are puzzled as to what to do about it. The public likewise is suffering from this misdirection, and is finding in the graduates of correspondence schools a measure of relief for which they have looked to us in vain. What we shall call for from the training schools in the development of this outside organized work is a woman who can go into any neighborhood, country or city, and become the friend and helper, guide and counselor of every faithful, capable worker who is devoting herself to the care of the sick and suffering. Not every nurse is capable of this, but every nurse, when she is getting her training, needs to know that her profession has such ideals for its leaders.

If a well-organized, comprehensive system of outside nursing can be established, using coordination of labor and making all-around service to the home the starting point, may there not be a chance of a better adjustment for the graduate nurse, and a wider field for her ability and proper service? I believe this wider field to be possible, because the proper and effective use of the graduate nurse must in the end be determined by the sickness—not by the pocketbook. Organized home nursing in other countries has produced organized methods of benefit insurance as soon as there is a service to insure for. Organization will doubtless accomplish this with us likewise, not only by reducing the service cost, but also by means of insurance, enabling large classes to finance themselves and to get continuous trained nursing when needed, instead of going without or depending upon charity. Social insurance, whether by public or by private enterprise, is a word we shall hear more of in future years, and there is no escape from the conclusion to which we are coming, that reliance on charity to meet sickness and other emergencies of life is not the way out for the classes who are the main support of the country. We can no more serve by charity the needs of those who support *us* than we can lift ourselves by our boot-straps.

Again, there is a possibility of simplifying another of your problems. Much thought and trouble are being given to the naming and grading of nurses in accordance with varied courses of training. Important as this may be, how can any diploma given months or years before decide fully the really vital question of how the right woman can be got to the right case? Can this ever be accomplished by the most perfect system of instruction if the products of your educational efforts are turned out with their certificates or diplomas into a weltering chaos to shift for themselves, as they have been for years?

I believe that an able superintendent of a general service office, knowing the individual woman, and understanding the needs of the individual case, can do more than many diplomas to get the right woman on the right case, provided only that the superintendent occupies an independent civic position, where she is bound to serve the public to the best of her ability; and if she has a real touch on the homes from which the best nursing material comes, she can do much to get that material which you need for your training schools.

To summarize, if summarizing is possible with what in itself can be little more than a mere outline:

Better organized service for the sick in the homes of the independent classes is a necessity.

The hospitals can no longer look only to the work within their walls, but must relate their work in a satisfactory manner with kindred work in the community at large. From them must come help, counsel, and assistance for organizing that outside work.

That work, if organized, will increase by a substantial percentage the efficiency of the hospitals themselves by helping them get the cases that they should have and to get them in time, and by relieving the hospitals of cases that should be taken home under proper conditions to make room for others in the hospital.

In addition to this, the proper organization of outside work and a better role for the graduate nurse in that outside work should produce more good material in the training schools, better results from hospital training, and a more satisfactory status in the community for the graduate nurse.

DETROIT COOPERATIVE HOSPITAL.

Group of Manufacturers Prepare to Give Scientific Care to Employees—New Educational Ideas Invoked.

With the passage, by the state of Michigan, of an employers' liability and workmen's compensation law, which became effective September 1, 1912, there immediately arose the necessity for more adequate hospital facilities for the care of injured workmen—not that industrial accidents would increase through the passage of this act, but because the responsibility of medical and surgical care for the injured was placed directly on the shoulders of the employer for the first three weeks following the accident. Through the passage of this law insurance rates immediately became much higher than heretofore, and a large number of employers decided it to be to their best interests to carry their own insurance. Realizing the shortsightedness of providing medical aid for an injured workman for but three weeks, and then turning him loose to shift for himself, thereby inviting in many cases additional treatment, tending toward the lengthening of the compensation period and entailing additional cost, a number of Detroit manufacturers got together and the Manufacturers' Mutual Hospital Association was organized.

A building at 484 Jefferson avenue was secured, being fairly centrally located for the manufacturers along the river front, who were the originators of the project, and has been completely equipped as a hospital. The building contains twenty-seven rooms, six baths, is steam heated, electrically lighted, has large grounds, and has front and rear entrances. The wards are large, light, and well ventilated, and the private rooms are exceptionally fine, due to the fact that the building was at one time the home of one of Detroit's most representative men.

The staff consists of men of recognized ability, graduates of Yale, Cornell, and Johns Hopkins universities, to which has been added considerable hospital experience, which immediately insures service of the highest quality. The hospital association is organized on a mutual plan, the members being assessed according to the number of their employees. Assessments are based on actual expenses, and rebates will be made should more funds be collected than absolutely necessary.

The method of handling the injured cases is as follows: An accident occurs in the establishment of a member; the injured party is immediately taken to the hospital, where proper aid is rendered. If the injury be of a serious nature, he is immediately assigned to a ward or room, and is then taken care of until he has entirely recovered and is able to return to work. Should the injury be of a minor nature, not necessitating a stay at the hospital, he is sent to his home, provided that conditions at his home regarding sanitation, etc., are favorable to his condition; if not, he is kept at the hospital. Those cases sent to their homes are instructed to return daily to the hospital for treatment, but, if they are unable to do this, a physician will call as often as possible, and treat them at their homes until they are either able to report at the hospital for further treatment or to return to work.

In addition to the staff of physicians, both in and outside, an inspector is employed, whose duty it is to keep track of every case that is being treated at home or that comes to the hospital, follow them up in changes of address, bring them in to the hospital if they do not report as instructed, make reports through the hospital to the employer, and in every way safeguard the employer's interests, so that the men receive the very best medical and surgical care and are returned to work within the shortest possible time.

A complete record of cases is kept at the hospital, such as history sheets, treatment and call records, full data regarding the nature of the accident, and in fact everything pertaining to each case. Should a difference arise between the employee and employer, making arbitration necessary, this detail information is immediately available.

This hospital plan is only a part of the general campaign of education which we are endeavoring to teach the workmen—that their interests are identical with those of the employer; that the employer is making every effort to work for their betterment in various ways, such as proper safeguarding of all machinery and dangerous places, giving them light and well ventilated, sanitary places to work; paying the highest possible wages; taking care of them when injured, realizing fully that such a course tends toward increased loyalty on the part of the workman, bringing about a closer cooperation and gradually decreasing the width of the chasm which has long existed between capital and labor.

A. A. TEMPLETON.
President Manufacturers' Mutual Hospital Association.

Corner Stone For Oakland's New Hospital.

The corner stone of the new $600,000 hospital for the University of California, at Oakland, is to be laid in February with great ceremony. The staff of the new hospital will consist of sixty physicians on the faculty of the medical school.

The hospital will face Parnassus avenue, and it will extend from Second to Fourth avenues. The eastern wing will be devoted to offices, libraries, laboratories, lecture rooms and the like, and the western portion will be given over to wards and rooms. The ground floor of the western portion will be set aside for clinics.

PROPOSED CHANGE IN THE FORM OF HOSPITAL VITAL DATA.

Statistical Experience Data of the General Memorial Hospital, New York City, from 1902 to 1911, Inclusive.

By FREDERICK L. HOFFMAN, LL. D., Statistician, the Prudential Insurance Company of America.

This hospital, during the period 1902-1911, treated 1,337 patients for malignant disease. Of this number, 531 were males and 806 were females. Of the total number treated, 460, or 34.4 percent, were cured; the number of improved was 391, or 29.2 percent; the number of not improved cases was 266, or 19.9 percent; and 115, or 8.6 percent, were either not treated or remained in the hospital at the end of the period. There were 105 deaths, equivalent to a fatality rate of 7.9 percent. For the different organs and parts the fatality rates were as follows:

Cancer of the face, 56 cases, with 2 deaths, or 3.6 percent; cancer of the eyes, 10 cases, with 1 death, or 10.0 percent; cancer of the lips, 30 cases, with no death; cancer of the mouth, 38 cases, with 5 deaths, or 13.2 percent; cancer of the jaw, 65 cases, with 2 deaths, or 3.1 percent; cancer of the head and neck, 196 cases, with 9 deaths, or 4.6 percent; cancer of the throat, 16 cases, with 1 death, or 6.3 per cent; cancer of the thorax, chiefly of the breast, 321 cases, with 8 deaths, or 2.5 percent; cancer of the abdomen, 144 cases, with 39 deaths, or 27.1 percent; cancer of the urinary and male genital organs, 23 cases, with no death; cancer of the upper extremities, 50 cases, with 1 death, or 2.0 percent; cancer of the lower extremities, 111 cases, with 5 deaths, or 4.5 percent; cancer of the female genital organs, 262 cases, with 26 deaths, or 9.9 percent; cancer of miscellaneous organs and parts, 15 cases, with 6 deaths, or 40.0 percent.

It is unfortunate for statistical and medical purposes that the results are not given separately for each sex. In view of the well-known fact that the mortality rate varies considerably for the two sexes in general as well as in hospital experience, it is obviously to small purpose to combine the two sexes and give the results as regards the cured, improved, and the deaths in a consolidated form.

The results of the hospital are, on the whole, decidedly encouraging. This is best illustrated in the comparatively low fatality rate of cancers of the female generative organs, numbering 262 cases, the proportion of the cured being 35.9 percent, the improved 34.0 percent, and the deaths 9.9 percent. There were 286 cases of cancer of the breast, including only three males, with a total mortality of 5, or 1.8 percent. The details of the gynecological cases are of special interest and are given in full in the appended tables. The value of the statistical portion of the annual reports of the General Memorial Hospital would be materially increased if the present method of tabulation were changed and in the future made to conform to the statistics of the Johns Hopkins Hospital, which differentiate not only the males and females, but also the white and colored. Of course, additional information would be of supplementary value, particularly the age distribution of the patients and the proportion of cured, improved, and deaths, according to divisional periods of life. All the required changes would not involve a material expenditure, but the value of the annual reports for the public at large would be considerably increased.

DISEASE.	Male	Female	RESULTS.							Total
			Cured	Improved	Not improved	Not treated	Not stated	Remaining	Died	
General Surgical.										
Face—										
Carcinoma, cheek	1	.....	.....	.....	1	.....	.....	.....	.....	1
Carcinoma, cheek, recurrent	.....	1	.....	1	.....	.....	.....	.....	.....	1
Epithelioma, cheek	14	7	12	3	4	1	.....	.....	1	21
Epithelioma, cheek and gums	1	.....	.....	.....	1	.....	.....	.....	.....	1
Epithelioma, cheek and orbit	.....	1	.....	.....	.....	.....	.....	.....	1	1
Epithelioma, face	5	.....	2	1	1	1	.....	.....	.....	5
Epithelioma, face and cheek	5	1	3	.....	1	2	.....	.....	.....	6
Epithelioma, face and scalp, recurrent	1	.....	.....	1	.....	.....	.....	.....	.....	1
Epithelioma, nose	3	.....	.....	2	1	.....	.....	.....	.....	3
Melano-sarcoma, face	1	.....	.....	.....	.....	1	.....	.....	.....	1
Sarcoma, face	5	9	.....	4	8	.....	.....	2	.....	14
Sarcoma, nose	1	.....	.....	1	.....	.....	.....	.....	.....	1
Total	37	19	17	13	17	5	.....	2	2	56
Eyes—										
Endothelioma, orbit	1	.....	1	.....	.....	.....	.....	.....	.....	1
Epithelioma, eyelid	.....	1	1	.....	.....	.....	.....	.....	.....	1
Epithelioma, inner canthus	1	.....	1	.....	.....	.....	.....	.....	.....	1
Epithelioma, lower eyelid	.....	1	.....	1	.....	.....	.....	.....	.....	1
Melanotic sarcoma, retina	.....	1	.....	.....	1	.....	.....	.....	.....	1
Sarcoma, orbit	4	1	1	.....	3	.....	.....	.....	1	5
Total	6	4	4	1	4	.....	.....	.....	1	10
Lips—										
Epithelioma, deformity of lip following excision of	1	.....	1	.....	.....	.....	.....	.....	.....	1
Epithelioma, lip	15	.....	5	3	1	1	5	.....	.....	15
Epithelioma, lip and submaxillary glands	1	.....	1	.....	.....	.....	.....	.....	.....	1
Epithelioma, lower lip	6	.....	4	2	.....	.....	.....	.....	.....	6
Epithelioma, lower lip and metastasis	1	.....	.....	1	.....	.....	.....	.....	.....	1
Epithelioma, lower lip and submaxillary glands	3	.....	3	.....	.....	.....	.....	.....	.....	3
Epithelioma, upper lip	1	.....	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, lower lip	2	.....	.....	1	1	.....	.....	.....	.....	2
Total	30	.....	14	8	2	1	5	.....	.....	30
Mouth—										
Carcinoma, tongue	7	.....	2	.....	1	1	.....	.....	3	7
Carcinoma, tongue, submaxillary involvement	1	.....	.....	1	.....	.....	.....	.....	.....	1
Epithelioma, floor of mouth	1	.....	1	.....	.....	.....	.....	.....	.....	1
Epithelioma, gums	1	.....	.....	1	.....	.....	.....	.....	.....	1
Epithelioma, mouth	1	.....	1	.....	.....	.....	.....	.....	.....	1
Epithelioma, soft palate	2	.....	.....	2	.....	.....	.....	.....	.....	2
Epithelioma, tongue	24	.....	12	3	3	3	1	.....	2	24
Sarcoma, hard palate	.....	1	.....	.....	1	.....	.....	.....	.....	1
Total	37	1	16	7	5	4	1	.....	5	38

DISEASE.	Male	Female	RESULTS. Cured	Improved	Not improved	Not treated	Not stated	Remaining	Died	Total
General Surgical—Cont'd.										
Jaws—										
Adamantinoma, lower jaw, recurrent	.....	1	.....	1	.....	.....	.....	.....	.....	1
Alveolar sarcoma, jaw	1	.....	.....	1	.....	.....	.....	.....	.....	1
Angio-sarcoma, upper jaw	1	.....	.....	1	.....	.....	.....	.....	.....	1
Carcinoma, lower jaw	4	4	1	3	3	.....	.....	.....	1	8
Carcinoma, upper jaw	.....	1	1	.....	.....	.....	.....	.....	.....	1
Endothelioma, submaxillary glands	.....	1	1	.....	.....	.....	.....	.....	.....	1
Epithelioma, inferior maxilla	3	1	1	1	.....	2	.....	.....	.....	4
Epithelioma, submaxillary glands	6	.....	4	1	1	.....	.....	.....	.....	6
Epithelioma, superior maxilla	4	1	.....	3	1	.....	.....	1	.....	5
Epulis, jaw	.....	2	2	.....	.....	.....	.....	.....	.....	2
Epulis, inferior maxilla	1	3	3	1	.....	.....	.....	.....	.....	4
Fibro-sarcoma, upper jaw	.....	1	1	.....	.....	.....	.....	.....	.....	1
Lympho-sarcoma, upper jaw and palate	1	.....	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, inferior maxilla	2	3	2	1	2	.....	.....	.....	.....	5
Sarcoma, inferior maxilla and neck	1	.....	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, jaw	.....	4	.....	1	2	.....	.....	.....	1	4
Sarcoma, submaxillary region	1	2	.....	3	.....	.....	.....	.....	.....	3
Sarcoma, superior maxilla	13	2	.....	7	8	.....	.....	.....	.....	15
Sarcoma, superior and inferior maxillæ	1	.....	.....	1	.....	.....	.....	.....	.....	1
Total	**39**	**26**	**16**	**27**	**17**	**2**	.....	**1**	**2**	**65**
Head and Neck—										
Adeno-sarcoma, thyroid	.....	3	.....	3	.....	.....	.....	.....	.....	3
Angio-sarcoma, neck	2	2	1	.....	2	.....	.....	.....	1	4
Carcinoma, antrum	2	2	1	3	.....	.....	.....	.....	.....	4
Carcinoma, branchio-genetic cleft	1	.....	.....	.....	1	.....	.....	.....	.....	1
Carcinoma, cervical glands	12	6	6	7	2	1	.....	.....	2	18
Carcinoma, head, recurrent	.....	2	.....	2	.....	.....	.....	.....	.....	2
Carcinoma, neck	12	3	.....	5	5	1	.....	2	2	15
Carcinoma, neck, recurrent	.....	2	.....	.....	.....	.....	2	.....	.....	2
Carcinoma, parotid	1	1	.....	1	1	.....	.....	.....	.....	2
Carcinoma, parotid region	1	1	1	1	.....	.....	.....	.....	.....	2
Carcinoma, thyroid	1	.....	.....	.....	1	.....	.....	.....	.....	1
Chondro-epithelioma, antrum	1	.....	1	.....	.....	.....	.....	.....	.....	1
Epithelioma, antrum	.....	1	1	.....	.....	.....	.....	.....	.....	1
Epithelioma, cervical glands	5	.....	2	2	.....	1	.....	.....	.....	5
Epithelioma, ear	1	.....	.....	1	.....	.....	.....	.....	.....	1
Epithelioma, forehead	1	2	2	1	.....	.....	.....	.....	.....	3
Epithelioma, neck	21	1	5	5	11	.....	.....	.....	1	22
Epithelioma, post-auricular glands	1	.....	.....	.....	1	.....	.....	.....	.....	1
Epithelioma, scalp	1	1	1	.....	1	.....	.....	.....	.....	2
Fibro-sarcoma, neck	1	.....	.....	.....	1	.....	.....	.....	.....	1
Hodgkin's disease	8	4	.....	6	5	.....	.....	.....	1	12
Hodgkin's sarcoma	3	.....	.....	3	.....	.....	.....	.....	.....	3
Lympho-sarcoma, neck	1	1	.....	1	1	.....	.....	.....	.....	2
Melano-sarcoma, neck	1	.....	.....	.....	1	.....	.....	.....	.....	1
Mixed tumor, parotid	1	.....	.....	.....	1	.....	.....	.....	.....	1
Myxo-chondro-epithelioma, parotid	1	.....	1	.....	.....	.....	.....	.....	.....	1
Myxo-epithelial tumor, parotid	.....	1	.....	.....	1	.....	.....	.....	.....	1
Sarcoma, thyroid gland	.....	1	.....	.....	1	.....	.....	.....	.....	1
Sarcoma, scalp	1	.....	.....	.....	.....	.....	.....	1	.....	1
Sarcoma, carotid gland	1	.....	.....	.....	1	.....	.....	.....	.....	1
Sarcoma, parotid gland	12	3	5	6	3	.....	.....	.....	1	15
Sarcoma, forehead	7	5	4	3	5	.....	.....	.....	.....	12
Sarcoma, forehead and face	.....	1	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, forehead and scalp	1	.....	.....	.....	1	.....	.....	.....	.....	1
Sarcoma, neck	38	11	4	18	18	6	.....	2	1	49
Sarcoma, neck, with metastases	1	.....	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, neck and orbit	1	.....	.....	1	.....	.....	.....	.....	.....	1
Tumor, occipital bone	1	.....	.....	.....	1	.....	.....	.....	.....	1
Total	**142**	**54**	**35**	**71**	**65**	**9**	**2**	**5**	**9**	**196**
Throat—										
Carcinoma, larynx	1	1	.....	.....	2	.....	.....	.....	.....	2
Carcinoma, throat	1	.....	.....	.....	.....	.....	.....	.....	1	1
Carcinoma, tonsil	1	1	.....	1	1	.....	.....	.....	.....	2
Epithelioma, larynx	2	.....	.....	2	.....	.....	.....	.....	.....	2
Sarcoma, nasopharynx	1	.....	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, tonsil	6	.....	.....	3	3	.....	.....	.....	.....	6
Sarcoma, tonsil and glands of neck	2	.....	.....	2	.....	.....	.....	.....	.....	2
Total	**14**	**2**	.....	**9**	**6**	.....	.....	.....	**1**	**16**
Thorax—										
Carcinoma, breast	.....	38	25	12	.....	1	.....	.....	.....	38
Carcinoma, breast, inoperable	.....	9	.....	1	1	1	.....	3	3	9
Carcinoma, breast, operable	1	128	114	7	1	1	.....	6	.....	129
Carcinoma, breast, recurrent	.....	47	20	11	9	4	.....	1	2	47
Carcinoma, breast and forearm	.....	1	.....	1	.....	.....	.....	.....	.....	1
Carcinoma, breast and axilla	.....	7	.....	7	.....	.....	.....	.....	.....	7
Carcinoma, breast, bilateral	.....	2	.....	.....	.....	2	.....	.....	.....	2
Carcinoma, breast, unilateral	2	37	30	7	1	1	.....	.....	.....	39
Celeno-carcinoma, breast	.....	1	1	.....	.....	.....	.....	.....	.....	1
Paget's disease	.....	1	1	.....	.....	.....	.....	.....	.....	1
Sarcoma, breast	.....	12	6	2	2	2	.....	.....	.....	12
Carcinoma, chest wall	1	.....	.....	.....	1	.....	.....	.....	.....	1
Melano-sarcoma, side of chest	1	.....	1	.....	.....	.....	.....	.....	.....	1
Epithelioma, chest wall	1	.....	1	.....	.....	.....	.....	.....	.....	1
Sarcoma, chest wall	10	3	.....	5	7	.....	.....	.....	1	13
Sarcoma, chest wall and rib	2	.....	1	1	.....	.....	.....	.....	.....	2
Sarcoma, clavicle	2	.....	.....	1	1	.....	.....	.....	.....	2
Sarcoma, mediastinum	2	1	.....	1	.....	.....	.....	.....	2	3
Sarcoma, pectoral region	11	1	2	4	5	.....	.....	1	.....	12
Total	**33**	**288**	**202**	**60**	**28**	**12**	.....	**11**	**8**	**321**
Abdomen—										
Carcinoma, abdominal viscera	.....	4	.....	.....	2	1	.....	.....	1	4
Carcinoma, abdominal viscera, inoperable	3	7	.....	.....	3	5	.....	.....	2	10
Carcinoma, ascending colon and omentum	.....	1	.....	.....	1	.....	.....	.....	.....	1
Carcinoma, ascending colon and cecum	.....	1	.....	1	.....	.....	.....	.....	.....	1
Carcinoma, intestines	4	2	.....	1	2	1	.....	.....	2	6
Carcinoma, cecum	.....	1	.....	1	.....	.....	.....	.....	.....	1
Carcinoma, head of cecum, inoperable	.....	1	.....	.....	.....	.....	.....	.....	1	1
Carcinoma, ileum	.....	1	.....	.....	.....	1	.....	.....	.....	1

DISEASE.	Male	Female	RESULTS. Cured	Improved	Not improved	Not treated	Not stated	Remaining	Died	Total
General Surgical—Cont'd.										
Abdomen—Cont'd—										
Carcinoma, descending colon	3	2	1	.....	.....	.....	.....	1	3	5
Carcinoma, sigmoid flexure, colon	.....	1	1	.....	.....	.....	.....	.....	.....	1
Carcinoma, sigmoid flexure and intestinal obstruction	1	1	.....	.....	.....	1	.....	.....	1	2
Carcinoma, colon	1	1	.....	.....	.....	.....	.....	.....	2	2
Carcinoma, omentum	1	1	1	1	.....	.....	.....	.....	.....	2
Carcinoma, rectum, inoperable	1	2	.....	2	1	.....	.....	.....	.....	3
Carcinoma, rectum and sigmoid	3	4	.....	1	.....	.....	.....	.....	6	7
Carcinoma, rectum	2	2	1	1	.....	1	.....	.....	1	4
Carcinoma, rectum, operable	3	4	1	4	1	.....	.....	.....	1	7
Carcinoma, cardiac end of stomach	.....	1	.....	1	.....	.....	.....	.....	.....	1
Carcinoma, pylorus	1	1	1	.....	.....	.....	.....	.....	1	2
Carcinoma, stomach	6	2	.....	2	2	2	.....	.....	2	8
Carcinoma, stomach, operable	1	9	3	2	1	.....	.....	.....	4	10
Carcinoma, stomach, inoperable	11	5	.....	3	5	5	.....	.....	3	16
Carcinoma, stomach, pyloric obstruction	.....	1	.....	1	.....	.....	.....	.....	.....	1
Carcinoma, lower end of esophagus	1	.....	.....	.....	1	.....	.....	.....	.....	1
Carcinoma, esophagus	4	.....	.....	.....	4	.....	.....	.....	.....	4
Carcinoma, liver	2	9	.....	1	4	3	.....	.....	3	11
Carcinoma, pancreas	.....	1	.....	.....	.....	.....	.....	.....	1	1
Carcinoma, retroperitoneal glands	1	.....	.....	1	.....	.....	.....	.....	.....	1
Carcinoma, gall bladder	1	2	1	2	.....	.....	.....	.....	.....	3
Angio-sarcoma, abdomen, pelvis	.....	1	.....	1	.....	.....	.....	.....	.....	1
Adeno-sarcoma, hepatic flexure, colon	.....	1	1	.....	.....	.....	.....	.....	.....	1
Fibro-sarcoma, mesentery	1	.....	1	.....	.....	.....	.....	.....	.....	1
Papillomatous cyst, abdomen	.....	1	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, abdomen	1	3	.....	.....	1	.....	.....	.....	3	4
Sarcoma, abdomen, wall	.....	1	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, abdomen, inoperable	.....	3	.....	3	.....	.....	.....	.....	.....	3
Sarcoma, abdomen, flank	1	1	.....	.....	1	.....	.....	.....	1	2
Sarcoma, intestines and pelvis	.....	1	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, ileum	3	2	1	.....	4	.....	.....	.....	.....	5
Sarcoma, mesentery	1	.....	.....	.....	.....	.....	.....	.....	1	1
Sarcoma, viscera	.....	1	.....	.....	1	.....	.....	.....	.....	1
Sarcoma, retroperitoneal glands	1	.....	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, rectum	2	1	1	.....	1	1	.....	.....	.....	3
Sarcoma, rectum, inoperable	1	.....	.....	.....	1	.....	.....	.....	.....	1
Total	**61**	**83**	**14**	**33**	**36**	**21**	.....	**1**	**39**	**144**
Genito-Urinary—										
Carcinoma, bladder	2	.....	1	.....	1	.....	.....	.....	.....	2
Carcinoma, prostate gland	2	.....	.....	1	1	.....	.....	.....	.....	2
Chondro-adeno-sarcoma, spermatic cord	1	.....	1	.....	.....	.....	.....	.....	.....	1
Carcinoma, testicle	1	.....	.....	1	.....	.....	.....	.....	.....	1
Carcinoma, penis	5	.....	3	2	.....	.....	.....	.....	.....	5
Carcinoma, penis and inguinal glands	1	.....	.....	.....	1	.....	.....	.....	.....	1
Sarcoma, kidney	1	1	.....	.....	2	.....	.....	.....	.....	2
Sarcoma, testis	6	.....	2	2	1	.....	.....	1	.....	6
Sarcoma, testis, abdominal metastasis	1	.....	.....	.....	1	.....	.....	.....	.....	1
Sarcoma, undescended testis	1	.....	.....	.....	1	.....	.....	.....	.....	1
Sarcoma, testis, recurrent	1	.....	.....	1	.....	.....	.....	.....	.....	1
Total	**22**	**1**	**7**	**7**	**8**	.....	.....	**1**	.....	**23**
Upper Extremity—										
Carcinoma, axilla	2	1	1	2	.....	.....	.....	.....	.....	3
Carcinoma, axilla and glands	.....	2	1	.....	.....	.....	.....	1	.....	2
Carcinoma, axilla and glands, recurrent	1	1	2	.....	.....	.....	.....	.....	.....	2
Carcinoma, axillary nodes	.....	1	1	.....	.....	.....	.....	.....	.....	1
Carcinoma, shoulder	2	1	2	1	.....	.....	.....	.....	.....	3
Epithelioma, arm	1	.....	1	.....	.....	.....	.....	.....	.....	1
Epithelioma, hand	2	.....	2	.....	.....	.....	.....	.....	.....	2
Epithelioma, arm and axillary glands	.....	1	.....	1	.....	.....	.....	.....	.....	1
Melano-sarcoma, arm	1	.....	1	.....	.....	.....	.....	.....	.....	1
Osteo-sarcoma, arm	1	.....	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, arm	3	2	2	2	1	.....	.....	.....	.....	5
Sarcoma, axilla	4	.....	1	2	1	.....	.....	.....	.....	4
Sarcoma, axillary glands, recurrent	1	.....	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, finger	1	.....	1	.....	.....	.....	.....	.....	.....	1
Sarcoma, hand	2	.....	1	1	.....	.....	.....	.....	.....	2
Sarcoma, shoulder	6	3	1	4	3	.....	.....	.....	1	9
Sarcoma, scapula	2	.....	.....	.....	2	.....	.....	.....	.....	2
Sarcoma, forearm	.....	2	.....	2	.....	.....	.....	.....	.....	2
Sarcoma, humerus	1	3	1	2	1	.....	.....	.....	.....	4
Sarcoma, radius	.....	1	.....	1	.....	.....	.....	.....	.....	1
Tumor (n.s.), axilla	.....	2	1	1	.....	.....	.....	.....	.....	2
Total	**30**	**20**	**19**	**21**	**8**	.....	.....	**1**	**1**	**50**
Lower Extremity—										
Carcinoma, ankle	1	.....	1	.....	.....	.....	.....	.....	.....	1
Carcinoma, inguinal glands	2	2	.....	3	.....	1	.....	.....	.....	4
Congenital epithelial tumor, leg	2	.....	1	.....	.....	1	.....	.....	.....	2
Epithelioma, femoral region	1	.....	1	.....	.....	.....	.....	.....	.....	1
Epithelioma, buttocks	1	.....	1	.....	.....	.....	.....	.....	.....	1
Epithelioma, thigh	.....	1	1	.....	.....	.....	.....	.....	.....	1
Epithelioma, thigh, recurrent	1	1	.....	2	.....	.....	.....	.....	.....	2
Giant-celled sarcoma, thigh	1	.....	.....	1	.....	.....	.....	.....	.....	1
Lympho-sarcoma, groin	1	.....	.....	1	.....	.....	.....	.....	.....	1
Melano-sarcoma, ankle	.....	1	.....	.....	1	.....	.....	.....	.....	1
Melano-sarcoma, inguinal region	.....	1	.....	1	.....	.....	.....	.....	.....	1
Osteo-sarcoma, leg	.....	1	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, ankle	2	1	2	.....	1	.....	.....	.....	.....	3
Sarcoma, inguinal region	4	2	.....	2	4	.....	.....	.....	.....	6
Sarcoma, inguinal, sarcomatous testis	1	.....	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, groin	9	6	2	6	5	.....	.....	.....	2	15
Sarcoma, inguinal lymph nodes	.....	1	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, inguinal region and thigh	2	.....	.....	1	1	.....	.....	.....	.....	2
Sarcoma, buttocks	3	2	2	2	1	.....	.....	.....	.....	5
Sarcoma, femur	6	4	2	2	6	.....	.....	.....	.....	10
Sarcoma, foot	.....	3	.....	3	.....	.....	.....	.....	.....	3
Sarcoma, hip	4	1	1	1	3	.....	.....	.....	.....	5
Sarcoma, ilium	1	.....	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, lumbar region	.....	1	.....	.....	1	.....	.....	.....	.....	1

DISEASE.	Male	Female	RESULTS. Cured	Improved	Not improved	Not treated	Not stated	Remaining	Died	Total
General Surgical—Cont'd.										
Lower Extremity—Cont'd—										
Sarcoma, leg, recurrent	1	.....	.....	.....	1	.....	.....	.....	.....	1
Sarcoma, pelvis	7	1	.....	3	4	.....	.....	.....	1	8
Sarcoma, pelvis, inoperable	3	.....	.....	.....	1	1	.....	.....	1	3
Sarcoma, popliteal space	1	.....	.....	.....	1	.....	.....	.....	.....	1
Sarcoma, tibia	1	2	3	.....	.....	.....	.....	.....	.....	3
Sarcoma, thigh	16	7	3	8	9	.....	.....	2	1	23
Subperiosteal albuminosa, femur	1	.....	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, toe	.....	1	1	.....	.....	.....	.....	.....	.....	1
Total	72	39	21	41	39	3	.....	2	5	111
Gynecological—Female Generative Organs Only.										
Carcinomatous cyst, broad ligament	.....	4	1	1	.....	.....	.....	1	1	4
Adenoma, cervix	.....	1	.....	.....	.....	.....	.....	.....	1	1
Carcinoma, cervix	.....	75	30	31	8	3	.....	3	.....	75
Carcinoma, cervix, inoperable	.....	1	.....	1	.....	.....	.....	.....	.....	1
Carcinoma, cervix and uterus	.....	1	.....	1	.....	.....	.....	.....	.....	1
Carcinoma, cervix and vagina	.....	4	.....	4	.....	.....	.....	.....	.....	4
Carcinoma, ovary	.....	12	4	3	1	1	.....	.....	3	12
Carcinoma, uterus	.....	20	10	6	1	.....	.....	.....	3	20
Carcinoma, uterus, inoperable	.....	42	.....	18	14	10	.....	.....	5	42
Carcinoma, uterus, operable	.....	38	23	7	.....	2	.....	.....	6	38
Carcinoma, vagina	.....	3	.....	3	.....	.....	.....	.....	.....	3
Adenoma, uterus	.....	3	2	1	.....	.....	.....	.....	.....	3
Adeno-sarcoma, uterus	.....	2	1	.....	.....	.....	.....	.....	1	2
Chorio-epithelioma, uterus	.....	1	.....	.....	.....	1	.....	.....	.....	1
Chorio-epithelioma, uterus and vagina	.....	1	.....	.....	.....	.....	.....	.....	1	1
Deciduoma	.....	1	.....	1	.....	.....	.....	.....	.....	1
Dermoid cyst, carcinomatous degeneration	.....	1	1	.....	.....	.....	.....	.....	.....	1
Fibro-sarcoma	.....	1	1	.....	.....	.....	.....	.....	.....	1
Malignant papilloma, ovary (involvement)	.....	1	.....	1	.....	.....	.....	.....	.....	1
Papilloma, ovary	.....	14	8	1	2	2	.....	.....	1	14
Papillary adeno-sarcoma, ovary	.....	1	1	.....	.....	.....	.....	.....	.....	1
Polypoid endometritis	.....	1	.....	.....	.....	.....	.....	.....	1	1
Epithelioma, cervix	.....	5	2	3	.....	.....	.....	.....	.....	5
Epithelioma, clitoris	.....	2	.....	2	.....	.....	.....	.....	.....	2
Epithelioma, labia	.....	3	1	2	.....	.....	.....	.....	.....	3
Epithelioma, labium minor, clitoris	.....	1	.....	1	.....	.....	.....	.....	.....	1
Epithelioma, ovary	.....	1	.....	1	.....	.....	.....	.....	.....	1
Epithelioma, uterus	.....	1	.....	1	.....	.....	.....	.....	.....	1
Epithelioma, vulva	.....	2	2	.....	.....	.....	.....	.....	.....	2
Sarcoma, uterus	.....	1	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, uterus, operable	.....	2	2	.....	.....	.....	.....	.....	.....	2
Sarcoma, uterus, inoperable	.....	1	.....	1	.....	.....	.....	.....	.....	1
Sarcoma, ovary	.....	13	5	2	1	1	.....	1	3	13
Sarcoma, vagina, recurrent	.....	1	.....	.....	1	.....	.....	.....	.....	1
Epithelioma	.....	1	.....	1	.....	.....	.....	.....	.....	1
Total	.....	262	94	89	28	20	.....	5	26	262
Miscellaneous and Unclassified Medical and Surgical.										
Blastomycosis	1	.....	.....	.....	.....	.....	.....	.....	1	1
Carcinomatosis	1	2	.....	.....	2	.....	.....	.....	1	3
General lymphoma	1	.....	.....	.....	.....	.....	.....	.....	1	1
Round-celled sarcoma	1	.....	.....	1	.....	.....	.....	.....	.....	1
Metastatic carcinoma	.....	1	.....	1	.....	.....	.....	.....	.....	1
Epithelioma	.....	1	.....	.....	.....	1	.....	.....	.....	1
Sarcoma, sacro-iliac region	2	1	1	1	.....	.....	.....	.....	1	3
Sarcoma, dorsal spine	.....	1	.....	.....	.....	.....	.....	.....	1	1
Osteo-chondro-sarcoma, ilium	1	.....	.....	.....	.....	.....	.....	.....	1	1
Sarcomatosis	.....	1	.....	.....	1	.....	.....	.....	.....	1
Sarcoma	1	.....	.....	1	.....	.....	.....	.....	.....	1
Total	8	7	1	4	3	1	.....	.....	6	15
Grand total	531	806	460	391	266	78	8	29	105	1337

SUMMARY OF THE FOREGOING DATA.

Group	Total Number	Total Percent	Male	Female	Cured Number	Cured Percent	Improved Number	Improved Percent	Not improved	Not treated	Not stated	Number remaining	Died Number	Died Percent
Face	56	4.2	37	19	17	30.4	13	23.1	17	5	.....	2	2	3.6
Eyes	10	0.7	6	4	4	40.0	1	10.0	4	.....	.....	.....	1	10.0
Lips	30	2.2	30	.....	14	46.7	8	26.7	2	1	5	.....	.....	.....
Mouth	38	2.9	37	1	16	42.1	7	18.4	5	4	1	.....	5	13.2
Jaws	65	4.9	39	26	16	24.6	27	41.5	17	2	.....	1	2	3.1
Head and neck	196	14.7	142	54	35	17.9	71	36.2	65	9	2	5	9	4.6
Throat	16	1.2	14	2	.....	.....	9	56.3	6	.....	.....	.....	1	6.3
Thorax	321	24.0	33	288	202	62.9	60	18.7	28	12	.....	11	8	2.5
Abdomen	144	10.8	61	83	14	9.7	33	22.9	36	21	.....	1	39	27.1
Genito-urinary	23	1.7	22	1	7	30.4	7	30.4	8	.....	.....	1	.....	.....
Upper extremity	50	3.7	30	20	19	38.0	21	42.0	8	.....	.....	1	1	2.0
Lower extremity	111	8.3	72	39	21	18.9	41	36.9	39	3	.....	2	5	4.5
Female gen. organs	262	19.6	.....	262	94	35.9	89	34.0	28	20	.....	5	26	9.9
Miscellaneous	15	1.1	8	7	1	6.7	4	26.7	3	1	.....	.....	6	40.0
Total	1337	100.0	531	806	460	34.4	391	29.2	266	78	8	29	105	7.9

COMPLETE EQUIPMENT OF A 100-BED CHILDREN'S HOSPITAL.

In the Furnishing of This Institution, Units Are Taken Rather Than Number of Patients—Nurses, Wet Nurses, Nursery Maids, Interns and Physicians Are Provided For.

By MISS ELIZABETH BURGESS,
SUPERINTENDENT MICHAEL REESE HOSPITAL TRAINING SCHOOL FOR NURSES.

This is the first of a series of papers giving lists of equipment for various kinds of hospitals. Of necessity, there can be no hard-and-fast rule concerning amounts, and prices are omitted as likely to be misleading rather than helpful. But these lists will be found to be very complete down to the minutest details, and it is hoped they will be a helpful guide to those who plan the equipment either of a children's ward or pavilion, or complete hospital. For very special reasons we have changed the originally intended order of the papers. Next month will be presented the equipment of a general hospital.

EQUIPMENT OF SARAH MORRIS HOSPITAL FOR CHILDREN.

BASEMENT.

Children's Play Room.

Crex rugs.
1 double swing.
1 merry-go-round.
2 blackboards.
2 bookcases and books.
Kindergarten table.
Kindergarten chairs.
Graphophone.
Toys.

Wet Nurses' Rooms—Each Room.

2 beds.
2 mattresses.
2 pillows.
1 dresser.
1 table.
1 rocker.
1 straight chair.
2 cribs.
2 crib mattresses.

Rooms are furnished on babies' floor for wet nurses during the day.

Milk Station.

Large ice chest.
Special utensil table.
Pasteurizer.
Sterilizer.
Stove.
Nurses' desk and chair.
Sinks.
Babcock tests.
Churn.
Separator.
Large amount table space.
Large amount shelving.

Milk Station—Small Equipment.

Aluminum basins.
Aluminum double boilers, several sizes.
Strainers.
Milk pitchers and pails.
Teakettle.
Wooden spoons.
Largest size Dover's egg beaters.
Gram scales.
Wire baskets for feeding bottles, holding 4, 6 and 8.
Numbered tags for bottles.
2 white enamel chairs.

Sewing Room.

1 large cutting table.
1 smaller table.
1 rocker.
3 straight chairs.
1 power sewing machine.
1 hand sewing machine.

Laundry.

1 Hurley washer.
1 steam dryer.
1 ironing board.
3 set tubs, one with steam fitting for boiling.
1 large table.
1 wall cupboard.
6 4-bushel laundry baskets.
1 clothes stick.
4 Mrs. Potts' sad irons.
2 iron rests.
1 dozen stocking stretchers.
1 dozen shirt stretchers.
1 sleeve board.
1 teakettle.
2 enamel pails.
Reagents.
Wax.
Soaps.

FIRST FLOOR.

Examining Suite—Waiting Room.

3 heavy plain wooden benches.

Surgical Examining Room.

1 examination table.
2 white enamel chairs.
2 white enamel stools, screw.
1 table.
1 desk table.
Instruments for simple dressings.

Examining Rooms.

Each to contain:
1 examination table.
2 white enamel chairs.
2 white enamel screw stools.
1 desk table.

Entry Bath.

Tub, set high.
1 table, white enamel.
1 infant scales set on table (Trommer).
1 roll wrapping paper attached under table.
1 stand scales.
1 white enamel chair.
1 white enamel stool, screw.

Cupboard to contain diapers, towels, shoes, shirts, stockings, night dresses, thermometer, chart, sheets, glass slides, ink and pens, twine.

Isolation for cases examined and waiting for Board of Health:

2 rooms containing toilets, running water.
1 white metal chair.
1 white enamel table.

Administration Suite—Reception Room.

Rug.
Mahogany center table.
Mahogany desk and chairs.
Mahogany settee.
Mahogany chairs, straight, 2.
Mahogany arm chair, 1.
Mahogany rocker, 1.

Office.

Rug.
Roll-top desk and chair.
Small flat desk and chair.
2 arm chairs.

SECOND FLOOR.

Typical Ward—12 Beds.

12 cribs.
12 mattresses, hair.
12 hair pillows.
12 feather pillows.
12 bedside tables, special pattern.
Nurses' desk, with rack for charts.
Desk, light.
Nurses' desk chair.
2 Wire screens for isolating units.
1 3-winged screen.
3 single screens.
2 low rockers.
2 straight adult chairs.
Thermometers.

Sun Porch.

1 low white enamel table.
8 kindergarten chairs.
2 low rockers.
2 wheel chairs.

Bath Room.

High tub.
Low tub.
Scales stand.
Low toilets.
Running water.
Mirror.
Thermometers.

Quiet Room.

1 crib.
1 mattress, hair.
1 hair pillow.
1 feather pillow.
1 table.
1 chair.

Individual equipment, kept by child's bed, except bed pan.

1 wash basin.
1 pus basin.
1 thermometer and jar.
1 comb.
1 fine comb.
1 tooth brush and mug.
1 small jar vaseline.
Bath blanket on shelf of bedside table for older children.

FIRST FLOOR.

Observation Department.

Each ward to contain:

- 2 large cribs.
- 2 hair crib mattresses.
- 2 feather pillows.
- 2 hair pillows.
- 2 basinettes.
- 2 basinette mattresses, hair.
- 2 small basinette hair pillows.
- 2 chairs.
- 2 white enamel tables (table inclosed on three sides with 2 shelves and towel rack at back).
- 1 single screen.
- Running water, with soap solution, $HycI_2$ 1-1000.
- Nail brushes and doctors' towels over basin.

A better plan than this is to have all large cribs together and small babies together. Such a plan would necessitate a very large department.

Serving Room—Typical.

- 1 serving table.
- 1 steam table.
- 1 gas plate.
- 1 rack for folding trays.
- Bed trays, 1 for each crib, excluding small babies.
- 2 waste cans (1 to be supplied clean when other is taken away).
- 1 chair.
- Dish pan.
- Drain basket.
- 3 serving spoons.
- 3 serving knives.
- 3 serving forks.
- 1 paring knife.
- 1 teakettle.
- 1 2-quart double boiler.
- 1 4-quart double boiler.
- 1 sauce pan.
- 1 fry pan.
- 1 steamer.
- 3 gray agate cups.
- 3 gray agate plates.
- Supply cans—
  - Tea.
  - Coffee.
  - Flour.
  - Salt.
  - Sugar, granulated.
  - Sugar, lump.
  - Pepper.
  - Cocoa.
- Crackers.
- Mustard.
- Egg poacher.
- Lemon squeezer.
- 2 small bowls.
- 1 egg beater.
- 1 spatula.
- 1 soap shaker.
- 1 can opener.
- 1 corkscrew.
- 2 large pitchers.
- 1 large sugar bowl.
- Dishes for each large child—
  - Cup and saucer.
  - Bread and butter plate.
  - Breakfast plate.
  - Soup bowl.
  - Sauce dish.
  - Egg cup.
  - Tumbler.
  - Vegetable dish.
- For every baby—
  - 1 mug.
  - 1 plate.
  - 1 soup bowl.
- Silver to each child—
  - 1 knife.
  - 1 fork.
  - 1 salt and pepper.
  - 2 teaspoons.
  - 1 soup spoon.
- For large children—private patients—
  - 1 silver creamer.
  - 1 silver sugar bowl.
  - 1 silver teapot.
  - 1 silver coffee pot.

Pattern of dishes different for each floor of hospital.

Typical Surgical Dressing Room.

- 1 instrument sterilizer.
- 1 utensil sterilizer.
- Hot and cold water sterilizer, small size.
- 1 dressing table.
- 1 stretcher.
- 1 dressing carriage, with irrigator.
- 2 white enamel chairs.
- 2 white enamel stools, screw.
- 1 instrument table.
- 1 large sink with overshelf for scrubbing-up articles.
- Cupboards for supplies.
- 1 dressing pail, covered.
- 2 sets of dressing instruments with jars of tubing, packing, and dressings peculiar to this hospital.

Isolation Room—For Care of Suspicious Cases.

- 1 crib.
- 1 mattress, hair.
- 1 feather pillow.
- 1 hair pillow.
- 1 white enamel metal chair.
- 1 single screen.
- 1 nurses' couch.
- 1 couch mattress.
- 1 feather pillow.
- 1 white enamel table.

Bath room containing individual articles for patient. Special articles provided:

- Bed pan.
- Urinal.
- Pus basin.
- Thermometers and jar.
- Vaseline.
- Comb, fine comb.
- Wash basin.
- Irrigating can and tubing.
- Enema tube.
- Hot-water bag.

Sink Room—Typical.

- 1 white metal table, 24x36.
- 1 white enamel stool, screw.
- 1 utensil sterilizer.
- 1 bed pan sterilizer.
- 1 gas plate.
- 2 rolling frames for canvas cloth bags.
- 24-hour specimen jars.
- Small specimen bottles.
- Disinfecting solutions.
- Bed pans, 1 for each child, labeled.
- Urinals.
- Cleaning utensils.

Babies' Ward—Typical.

- 10 basinettes for very young babies.
- 4 to 6 high-sided small cribs.
- 1 nurses' desk with rack for charts.
- 1 nurses' chair.
- 3 low rockers, adult.
- 2 straight chairs, adult.
- 1 desk light.
- 1 examining table.
- Hair mattresses.
- Small hair mattresses.
- Strictly individual articles in wall cupboard by each crib.

Baby Bath Room.

Equipment of mixing tank, with thermometers to indicate temperature.
Sprays for bathing infants.
Small low white table with dressing articles, as jar cotton, toothpick swabs, safety pins, needle, thread, powder.
2 very low white rocking chairs.
1 table with Trommer baby scales.
Ice chest, also heating closet.
Ice chest used for rack of bottles.
Heating closet, containing baby shirts, bath towels, baby towels, diapers, stockings and night dresses.
2 cans for diapers, 1 for soiled diapers, 1 for wet diapers.
Paper bags for cotton and waste.

Incubator Room.

- 1 electric incubator.
- 2 electrically heated cribs.

Private Corridor—Typical Private Room.

- 1 brass crib with hair mattress, hair and feather pillows.
- 1 nurse's couch with hair mattress, feather pillows.
- 1 bureau, with glass top.
- 1 table, with glass top.
- 1 armless rocker.
- 1 straight chair.
- 1 drop light.
- 1 electric fan.
- 1 screen.
- Swing screen also at door.
- Each room provided with individual articles for child.
- 2 rugs.

Floor covered with an imported linoleum, glued to cement foundation and flush with terrazzo baseboard.
Bath room and serving room on this floor as on others.

Operating Room Suite.

- 2 main operating rooms.
- 1 nose and throat room.
- Doctor's room.
- Nurses' work room.
- Sterilizing room.
- Sink room.
- 1 preparatory and anesthetising room.
- Blanket heater and drying room.

Doctors' Room—With Bath.

- 1 willow couch.
- 1 center table.
- 2 straight chairs.
- Lockers for clothing.

Nurses' Work Room.

- Cupboards built in.
- 1 enamel work table 6x2 feet.
- 4 white metal chairs.

Instrument Sterilizing Room.

- Hot and cold water sterilizer.
- 1 utensil sterilizer.
- 2 instrument sterilizers.
- 1 heater for salt solution.
- Large dressing sterilizer.
- Shelf for scrubbing instruments, etc.

Sink Room.

Sink—place for mops, brushes and cleaning articles.
Gas stove.

Operating Rooms.

- 1 operating table.
- 1 instrument table.
- 1 New York table.
- Rack for instrument trays.
- Sponge rack.
- Irrigating stand.
- Dressing sponge drum stand.
- Utensil stand.
- Standing light.
- Stools for operators to stand on.
- Enamel screw stools.
- Anesthetist's table.

Equipment in nose and throat room the same, but specially made for nose and throat work.
Instrument cabinets built in.

List of Instruments.

2 Aneuryson needles (1 right, 1 left).
6 sharp curets (2 large, 2 medium, 2 small).
½ dozen single vulsellas.
½ dozen double vulsellas.
1 dozen 8-inch clamps.
½ dozen flat retractors.
½ dozen dull retractors.
½ dozen sharp retractors.
3 Kocher directors with perforation.
6 pairs tissue forceps with teeth.
6 pairs tissue forceps without teeth.
3 pairs small tissue forceps without teeth.
6 grooved directors.
4 tenaculum.
1 dozen probes (4 large, 4 medium, 4 small).
6 needle holders.
2 dozen curved artery snaps.
4 dozen plain artery snaps.
3 dozen small Kocher snaps.
4 dozen Kocher snaps, regular size.
4 intestinal clamps (2 small, 2 medium).
3 Crozier forceps.
Potaine aspirator and needles.
3-ounce metal syringe.
1 record syringe (needles assorted sizes).
6 pairs curved scissors.
4 pairs angle scissors.
4 pairs dressing scissors.
2 pairs stitch scissors.
Needles, assorted.
Knives, large and medium.
Bone and cranial instruments, complete.
Tonsil and adenoid instruments, complete.
8 pairs dressing forceps.
3 pairs nail scissors.
3 nail files.
Portable light.
6 ether masks.
3 Heister mouth gags.
3 regular mouth gags.
6 tongue forceps, 3 of each.
Tracheotomy instruments.
Intubation instruments, complete.
Filiform flexible rubber catheters.
Small self-retaining retractor.
4 Crile clamps.
Extra drums for operating room dressings.
Three dressing drums for each dressing room.

Linen Supply.

10 large sheets per bed.
10 draw sheets per bed.
6 quilted pads per bed.
3 spreads per bed.
6 pillow cases per bed.
6 face towels per bed.
4 bath towels per bed.
4 doctors' towels per bed, small.
3 dressing towels per bed.
1 medicine towel per bed.
4 wash cloths per bed.
10 bibs per bed.
6 nightgowns per bed.
30 diapers for each infant.
2 sets screen covers per screen.
2 sets window curtains per window.
2 sets couch covers per couch.
4 bureau and table covers per table and bureau.
12 napkins for each P. R.

For entire 125 beds—
200 hot water bag covers.
150 ice cap covers.
60 baby bottle warmers.
50 canvas bags for linen.

Miscellaneous.

For basinettes—
10 sheets each.
10 quilted pads each.
4 spreads each.

Blankets—
4 single bed blankets for each crib and basinette.
2 single bath blankets for each crib and basinette.

For entire house—
80 single blankets for operative cases.
12 pairs blankets for operating room.
50 outdoor or chair blankets.

Clothing.

Baby shirts, small size.
Baby shirts for larger children.
Stockings, cashmere, for small babies (white, blue, pink).
Stockings, cotton, for larger children (white).
Waists and garters.
Petticoats on waists.
Flannelette petticoats.
Drawers, flannel and cotton.
Shoes, high shoes for small children.
Shoes, a few larger sizes.
Slippers, all sizes.
Caps, a few.
Mittens.
Coats, a few.
Hoods, a few.
Colored apron dresses.
Colored rompers.
Pajama suits for little boys.
Bed jackets made of daisy cloth, different colors.
Restraints of canton flannel.
Flannel jackets and leggins for operative cases.
Flannel for baby bands.

Extra Articles—For Use All Over House.

Knee rolls covered with rubber.
Rubber sheeting.
Rubber pillow cases.
Rubber aprons.
Extra hair and feather pillows.
Scrap baskets.
Hot-water cans, for heating beds.
Croup kettles.
Electric stoves for above.
Racks for holding irrigating cans.
Back rests.
Pails with rack for warming bottles.
Cradles.
Sand bags.
Vases.
Electric fans.
Thermos bottles.
2 air beds.

Census Bureau's List Of "Death Causes."

The bureau of the census, Department of Commerce, has recently issued a new edition of a vest-pocket list of "causes of death." The terms used are part of an internationally accepted nomenclature, in the preparation of which the "Bellevue" and "London" nomenclatures were consulted, with many of the references taken from the nomenclature issued by the registrar-general of England and Wales.

Two years ago the first issue of this booklet was sent to every physician in the United States, and the census bureau reports that it has helped materially in simplifying the vital statistics of the country and bringing them into such order that far better deductions can be made.

Hospitals are interested in the governmental list because one of the difficult hospital problems is to get death certificates made out acceptably to local, state, and national authorities, especially at points where there is no very responsible health service. Every hospital should send to the census bureau for this little book, and should make their death certificates conform to its provisions, excepting when local health departments have their own system.

Philadelphia Children's Hospital Advertising.

The Children's Hospital of Philadelphia, a complete set of new buildings for which are under way, is issuing a novel and successful series of pamphlets on the needs and growth of the institution. Progress on the new buildings is shown from issue to issue in picture form, some in colors, and there are also interesting snap shots of the children now occupying the old buildings. Little historic incidents in the career of the hospital are told in a most entertaining way, and vital facts are given.

Altogether four of a series of seven booklets have already appeared. This method of attracting intelligent notice to a most worthy philanthropy seems exceptionally good. It is to be hoped that the large amount of money needed, about $1,000,000, will be forthcoming.

List of New Members of the American Hospital Association.

Chas. H. Adams, member State Board of Charity, 590 Orient avenue, Melrose, Mass.

M. M. Bosworth, trustee City Hospital, Memphis, Tenn.

Dr. Louis C. Bosher, trustee Stuart Circle Hospital, 22 East Franklin street, Richmond, Va.

W. T. Barbour, trustee Grace Hospital, 1360 Jefferson avenue, East Detroit, Mich.

Miss Margaret S. Bailey, assistant superintendent Wesson Memorial Hospital, Springfield, Mass.

Dr. O. F. Ball, Modern Hospital, Metropolitan Building, St. Louis, Mo.

Miss Mary R. M. Beer, superintendent St. George Hospital, Iron Mountain, Mich.

Miss Donna G. Burgar, superintendent Noble Hospital, Westfield, Mass.

Chas. Butler, trustee Society for Relief of Orphans Hospital, 16 East 23d street, New York.

Dr. Richard C. Cabot, physician Massachusetts General Hospital, 1 Marlboro street, Boston, Mass.

Dr. Robt. G. Cabell, Jr., superintendent City Hospital, Richmond, Va.

Miss Lillian Carson, assistant superintendent West Philadelphia Hospital for Women, Philadelphia, Pa.

Chas. W. Comfort, Jr., M. D., superintendent New Haven Dispensary, New Haven, Conn.

Miss Annie E. Crozier, R. N., superintendent Heaton Hospital, Montpelier, Vt.

Dr. Robt. L. Dickinson, M. D., physician Brooklyn and Episcopal Hospital, 168 Clinton street, Brooklyn, N. Y.

Miss Katherine Dütting, assistant superintendent Franklin County Hospital, Greenfield, Mass.

Miss Annie J. Fletcher, matron Lynn Hospital, Lynn, Mass.

R. P. Fox, superintendent Babies' Hospital, Philadelphia, Pa.

A. O. Fonkalsrud, superintendent Norwegian Hospital, 425 Fourth avenue, Brooklyn, N. Y.

Frank Graham, gynecologist Memphis City Hospital, Memphis, Tenn.

Frederick D. Greene, general secretary Hospital Saturday and Sunday Association, 105 East 22d street, New York.

Miss Susan V. Gifford, assistant superintendent New York Hospital House of Relief, 67 Hudson street, New York.

Louis Hornheimer, trustee Ohio Valley General Hospital, Wheeling, West Va.

Nellie R. Hamill, superintendent Williamsburg Hospital, Brooklyn, N. Y.

Henry F. Harris, trustee Worcester City Hospital, 340 Main street, Worcester, Mass.

Adeline Henderson, superintendent of nurses New York Hospital, 8 West 16th street, New York.

George F. Holmes, assistant superintendent New York Hospital, 8 West 16th street, New York.

Helen Sinclair Howes, social service worker, 414 East 55th street, New York.

Henry James, Jr., manager Rockefeller Institute, 66th street and Avenue A, New York.

Fred H. Klaer, member Hospital or Charities Association, University of Pennsylvania, 1805 Pine street, Philadelphia, Pa.

Alice L. Lake, superintendent of nurses Worcester State Asylum, Worcester, Mass.

E. M. Lawler, superintendent of nurses Johns Hopkins Hospital, Baltimore, Md.

B. Malone, surgeon Memphis City Hospital, Memphis, Tenn.

James W. Manary, M. D., Boston City Hospital, Boston, Mass.

Greta Mabery, R. N., superintendent Massachusetts Babies' Hospital, Jamaica Plains, Mass.

Chas. S. Millet, trustee Millet Memorial Hospital, East Bridgewater, Mass.

Chas. W. Mosley, trustee Anna Jacques Hospital, Newbury Port, Boston, Mass.

Rachel Mulheron, assistant superintendent Grace Hospital, Willis and John streets, Detroit, Mich.

May MacLeod, superintendent Bessey Hospital, 845 Beacon street, Boston, Mass.

Alexander J. McRae, M. D., Wilkes Barre City Hospital, Wilkes Barre, Pa.

Miss Clara D. Noyes, superintendent of nurses, Bellevue Hospital, New York.

Alfred Paull, trustee Ohio Valley General Hospital, Wheeling, West Va.

Lucy J. Potter, superintendent Trull Hospital, Biddeford, Me.

Elizabeth E. Rae, R. N., superintendent Hospital of the Woman's Medical College, 2121 North College avenue, Philadelphia, Pa.

Edward W. Sheldon, trustee New York Hospital, 46 Park avenue, New York.

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Howell Wright, superintendent Cleveland City Hospital, Cleveland, Ohio.

Dr. M. B. Whyte, Riverdale Hospital, Toronto, Ontario.

Phoebe E. McCaffrey, superintendent of nurses, Solvay General Hospital, Detroit, Mich.

Annie W. Goodrich, state inspector Education Department, Albany, New York.

Polhemus Lyon, chairman Cape Hospital Board, Box 8, Cape Town, South Africa.

Gift Days for Hospitals.

Apple Day in Oregon.—November 18 was "apple day" in the big-red-apple state. In nearly every city and town apples became, for the day, the legal tender, and the receipts were turned in to the hospitals for the benefit of the sick. At the theaters apples paid for tickets, and also in many restaurants, hotels, and places of amusement. All the receipts were given to the hospitals as Thanksgiving gifts.

Annual Sale in Corning.—The annual sale of the Corning hospitals conducted by the members of the various chapters of ladies who make it their duty all the year around to work for the support of the hospitals, was held at the Odd Fellows' temple, Thursday afternoon, November 5, at 2 o'clock, to continue through November 6 and 7. The exhibit of fancy work this year was greater and more pleasing than ever. Supper was served at the hall in the evening, and there was dancing.

At Wijhi, Holland, a society has been organized whose aim is to bring about improvement in the care of the sick, especially the home care. It is proposed to establish, in addition to a visiting nurse system, a bureau for loaning apparatus and appliances for the care of surgical and difficult medical cases in their homes.

The MODERN HOSPITAL

Editorial Office . . . . . Monroe Building, Chicago
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EDITORS.

Henry M. Hurd . . . . . Calvert Building, Baltimore
Frederic A. Washburn . Mass. General Hospital, Boston
Winford H. Smith . . Johns Hopkins Hospital, Baltimore
S. S. Goldwater . . . . . Mt. Sinai Hospital, New York
James G. Mumford. . . . . Clifton Springs, New York
W. L. Babcock . . . . . Grace Hospital, Detroit
John A. Hornsby . . . . . Tower Building, Chicago

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Contributors, subscribers, and readers will find important information on advertising page 26.

Hospital Boards of Trustees.

The methods of some of our boards of trustees are antiquated and in need of reform. Customs that these same men would never think of following in their own business are used at the hospital. In one large hospital a medical superintendent is employed, but he is given little responsibility. Small questions of detail are referred to committees of the board. The superintendent cannot fix the salary of an engineer or fireman without the sanction of a committee. Such a policy leads to delay and dissatisfaction. No man of ability will long retain a position under such restrictions. The greatest efficiency comes when the superintendent is given large responsibility and is required to produce results. The present anomalous condition of some hospitals is perhaps due to the fact that the trustees' methods are the same today as when the hospital was smaller and ways which are now obsolete were more workable.

Many hospital directors do not require the presence of the superintendent at their meetings. These same individuals would not think of discussing the business affairs of a manufacturing or transportation corporation of which they are directors without the presence of the executive officer, and yet their knowledge of these business matters is usually greater than is their knowledge of the complex affairs of a great modern hospital.

We would all like our trustees to have a more intimate knowledge of our problems. One way to secure this is to require the presence of the superintendent at board meetings.

FREDERIC A. WASHBURN.

The Fifth or Hospital Year.

The fifth "clinical year" for the practical application of the knowledge gained in scientific study by the candidate for a medical degree is receiving careful study and discussion on the part of medical educators in several parts of the country. That the student should have the opportunity of making practical application or test of his theoretically-gained knowledge is generally demanded. The means to this desired end are advisedly the basis of discussion.

How shall the embryonic student apply his knowledge and acquire the art of practicing medicine? Shall we permit him to acquire his art as we acquired ours, at the expense of the patient and the mortality statistics, or shall we supervise his acquisition of practical knowledge by obligating him to take a "fifth clinical year," where from necessity he must act as an assistant in the closest possible proximity to the real problems in medicine and surgery? That the large general hospitals offer the best field for practical training in the "fifth year" has been alleged and conceded by many. Granting that this admission is true, it obviously follows that the efficiency of the practical work will depend on the surrender of the time and talents of the clinical teachers of medicine and surgery in the communities where this training is attempted. A prerequisite to the efficient use of the "fifth year" is a classification and standardization of hospitals. A serious move has been made in this direction by a committee of the American Medical Association and a committee of the American Hospital Association. It is to be hoped that the Carnegie Foundation can be induced to take up this work as they took up the work of standardizing and classifying medical colleges. Assuredly it is quite impossible for the hospitals to classify themselves and, to a certain extent, standardize their work. It is well known that early attempts to standardize the medical colleges from the inside were lamentable failures.

It is known that two viewpoints exist in reference to the "fifth year" as an available "clinical year." Several colleges have already absorbed the fifth year as a part of their regular curriculum, and will demand that the "clinical year" be the sixth year. These differences must be recon-

ciled. Obviously the basis of such a reconciliation must be a greater uniformity of requirements for admission to undergraduate medical schools and a country-wide uniformity in the teaching curriculum covering the first four or five years. It is a far cry from the high school platform to the A. B. and kindred degrees. Yet this difference exists in admission requirements of class "A" medical colleges. Before a "hospital year" can be made obligatory, it will be necessary to reconcile these differences.

The Council on Medical Education of the American Medical Association in their report to the House of Delegates at the last meeting showed an astonishing number of hospitals throughout the country that were struggling along without medical interns. Some of the replies received indicated that many of these hospitals were "happily" struggling without a resident staff. The proposition that many well-conducted hospitals isolated from teaching centers can do better without interns than with the young medical graduate can be readily proven.

Since reading this report of the Council giving the number of interns in hospitals and the number of hospitals operating without interns, the writer has had a great desire to have the investigation pursued still further in the direction of an attempt to ascertain the number of young medical interns who completed one year of hospital service.

The small hospitals without resident staffs are a community necessity, and many of them will have to be divorced from the general problem of medical education. An obligatory, or even an optional, "fifth year" will per force of emulation soon include many of these hospitals in the class with the large general hospitals, and all standards of service will be elevated by the "clinical year."

It would be a mistake for medical educators to assume that hospitals have been established for the teaching of medicine rather than for the care of the sick. The primal object of every hospital is the skilled care of the sick. Rather should we consider hospitals as a vehicle and adjuvant to the practical application of the scientific knowledge of the medical student; in other words, the medium through which he may be taught and supervised in the application of his art. It is true that the first aim of hospitals—the care of the sick—will be enhanced and improved by scientific teaching of young medical men in hospital wards. This, however, will be the resultant of associated endeavor, and is not a basic argument for the use of hospitals as teaching centers.

An experience of many years in hospital work leads me to assert that the large general hospitals of the country will welcome either an obligatory or optional "fifth year," and in the effort to meet the requirements of the situation they will put forth every effort to place themselves in hospital class "A."

Much of the criticism directed against hospital organization in the past is a direct reflection on the medical profession. The jealousies and shortsightedness of professional management have brought about the nonprofessional or lay management of some of our best hospitals. It is possible that this is a direct sequence of the lack of executive and administrative training on the part of medical men. It is not surprising that a profession as absorbing, humanitarian, and scientific as the profession of medicine finds that its votaries lack breadth and acumen in business matters.

Personally, the writer believes in lay boards of trustees for hospitals, as they are more likely to be free from medical politics and professional influence or entanglements. He is also a firm believer in the systematic and practical training of medical men for administrative hospital positions as a solution of the many problems that appear as the result of faulty organization and administration in many of our hospitals. This question of organization has an extremely important bearing on the efficiency of any given hospital in providing a "fifth clinical" year for medical students.

Pending the classification and standardization of hospitals, it is entirely feasible for many of the class A medical colleges of the country to arrange affiliation with well-known general hospitals for an optional "fifth year." This step has been recommended by the Council on Medical Education of the American Medical Association, and assurances have been given that the experiment will be tried in more than one teaching center. That the effort will be eagerly watched and its lessons welcomed is assured. Much encouragement in this direction has already been given to the medical colleges by hospital authorities in several centers, and hospital administrators should welcome the attempt as a step toward greater efficiency and stability in resident hospital staff service. It is to be hoped that the development of this idea in the future will bring about the recognition of hospital diplomas that will be as eagerly sought for as were the certificates of the old London hospitals fifty years ago.

Twenty years ago barely 20 percent of the graduates of our medical colleges were able to receive hospital positions. Owing to the rapid increase in the number of hospitals and a decrease in the number of medical graduates, it is now possible for nearly 80 percent of the graduates of our medical schools to take residentships

in hospitals for one, two, or three years. A "fifth clinical year" will increase the percentage of opportunities for undergraduate medical students, and will insure greater stability and earnestness on the part of the intern. The hospital, in its turn, will be forced to provide adequate practical teaching facilities, staff libraries, and improved resident accommodations. If good order, satisfaction, and efficiency are to result from the "fifth year," it will be necessary to provide adequate scientific supervision on the part of the best clinical teachers. Much of the routine work now carried out by interns must be relegated to other hands, and the progress of the student's application of theory to practice must be guided by strong hands.

The trend of discussion and opinion is slowly centering toward the establishment of a "fifth hospital year" as a prerequisite for state license. It is evident that but a few years will elapse before it will be a requirement. From the standpoint of the medical educator and the medical student it will prove of inestimable and far-reaching value, and from the viewpoint of the hospital it is a consummation to be desired.

WARREN L. BABCOCK.

Sanatorium Methods—II.

Frequently in these columns we have asserted the value of cooperation in the treatment of difficult cases—not only in sanatorium practice, but in general hospital practice, and eventually in private practice. This method, when fully developed in this country, may properly be called the American method, and will prove a far more sound, honest, and scientific practice than that of the famous continental and British watering places. It is true, as one of our contributors stated in our last issue, that an ideal health resort, after the European model, state controlled, and free alike to all venders—whether hotel keepers or shop keepers, theatrical troupes, amusement promoters, or physicians—would be a very pleasant place, would do much good in the gross, would be a lucrative investment, and of world-wide renown. But the earnest scientific man, properly trained and intent on promoting medicine, shrinks from the thought of such an association. Let us by all means surround our sanatoriums and our patients with every accessory of comfort, uplift, and happiness —physical, psychical, esthetic. No one more than this writer appreciates the value of all these things. But we must keep such accessories strictly in hand; strictly directed, immediately or remotely, by practitioners of scientific medicine. In addition to the pleasant and festive features of the continental resorts, we see among them numerous independent physicians, free of control and practicing unmoved upon the bodies of the sick. This is a horror which we trust may never secure a stronger foothold than at present, even in America. "What!" said a well-informed German internist to this writer, "you would go to those German baths? But why and to whom? There are twenty-seven doctors there—bad fellows; what you call quack; no one fit to treat my cat. Such is our amiable habit. We are free to fleece you Americans and English, and the Government smiles." Doubtless he spoke bitterly, and more than the truth; but suspicion lingers. Of course, there is a certain value in our contributor's suggestion that "a physician could refer his patients to another physician in whom he has confidence in such a resort for a day, for a month, or for six months, without the fear that his patient would be retained twice as long as the period for which he was sent." Very true, but the ideal American sanatorium, with its trained cooperating staff, should be able to do much more for physician and patient than merely to carry out some prearranged routine treatment in a given time. Such a staff should be competent, with its immense experience of similar cases, to help the physician with advice and the patient with those measures properly indicated in the progress of the disease and its frequent complications. As for the time of stay in the sanatorium—who may predict in advance the length of time suitable for treatment? And we must assume honesty and fair dealing on the part of such a proper sanatorium staff as we have in mind.

Then, there is that further question of the relation between the medical staff and the business management. A sanatorium or a hospital conducted purely for commercial purposes must necessarily be in the hands of a business man of the hotel-manager type, and is in principle an abomination unworthy of discussion in a serious medical journal. A proper sanatorium is a medical institution, and should be under the direction of a physician. Unfortunately, this obvious fact is sometimes disregarded, and the trustees or other responsible authorities employ a business manager, who is placed over the medical director and the staff. In such a case the sanatorium is bound to suffer from the abuses our contributor suggests—"the business manager takes the ground that it takes so much to get the patient to the sanatorium, and therefore the physicians must keep him there as long as possible; that the medical men have been expected to order as many of the more expensive forms of treatment as possible for the good of the service; that the physicians in

certain institutions have been required to send misleading reports to the family . . . in order to induce a longer residence, and that at certain other institutions the physicians are required to try to make the patient believe that that sanatorium is the only place in the world where he stands the least chance of securing the improvement of his condition." Revolting as these bits of gossip may be, they are certainly current. Such conditions as are here described seem inseparable from a purely commercial business management. Happily, these practices bring their own punishment. They become known, they destroy confidence, and they alienate the medical profession. The wretched sanatorium physicians, downtrodden by the business management, must inevitably decline in morale and efficiency, or else they must rebel and retire, denouncing the institution from which they escape. To the honor of the medical profession, such rebellion is not uncommon.

We do not believe, however, that the panacea is a development of such a sanatorium into a great state enterprise, with multiplied and extended commercial activities. When a medical institution escapes from good medical tradition and allies itself with amusement features, however psychically valuable, it is treading on dangerous ground. Amusement and recreative features are useful servants, but not for a moment must they be regarded as allies and as equals. We cannot touch pitch and remain undefiled.

JAMES G. MUMFORD.

The American College of Surgeons.

There was held in Chicago during the past week a congress of surgeons. Nearly five thousand medical men attended. Many of them did not pretend to be surgeons, but they visited the conference to see modern surgery. Many clinics were held.

At the end of the conference eight hundred of the visitors were inducted into fellowship in the American College of Surgeons, an institution which is an outgrowth of the clinical congress which has been held for three years past. As a result of the selection of the eight hundred Fellows there are many heart-burnings, some jealousy and envy, and many prophecies and misgivings as to what the future holds for this new organization.

THE MODERN HOSPITAL welcomes the American College of Surgeons. We believe that it has an opportunity for great usefulness, and, if its course shall be steered right, its creation should result in less surgery and better surgery in this country. We all know very well that incompetent men have been doing needless surgery, and that it is the tendency of the time for men to proclaim themselves surgeons who have had neither the training nor the experience to justify major work on their part.

A study of the list of eight hundred men who form the nucleus for this new organization is reassuring. Most of them are known to be men of experience and training, and most of them are known to be men of high ideals. Unfortunately some of them are not, but no group of eight hundred people could ever be brought together that could not be criticised. Without doubt fellowship in the American College of Surgeons will bring dignity and prestige, but, if this is all it brings, the American College of Surgeons will not live long. These men have been exalted or have exalted themselves into high place in the councils of their profession, and with this high place they must charge themselves with proportionately great responsibility.

From the hospital administrator's standpoint there are many weaknesses in the surgery of our day in this country. Is it possible that this new association can formulate rules that will become the standards and guide of their fellows? Is it possible to establish some definite understanding concerning some things that we hospital people greatly need?

There is no doubt that surgical technic from the standpoint of the hospital administrator is growing top-heavy. It is taking too many people in the operating rooms to wait on the surgeon. Operating rooms are becoming littered up with too much apparatus and furniture. The technic concerned in the nursing department and in the intern department is growing too complex.

There was an immense amount of truth in the statement of Dr. John B. Murphy a few days ago that medicine and not surgery would be at the forefront in the next decade. Today it seems that in every hospital every department must be subordinated to the surgery. Will not this new association give consideration to this suggestion by placing modern surgery in its proper attitude to and to its proper dimensions in the modern hospital?

Going back over a few years, it seems to at least this writer that the nurse is not receiving her patient back from the operating room in as good condition as he ought to be in; evidences of shock seem to be growing, and the patients seem to be longer in recovering from operation than they did a few years ago. Why is this? Are surgeons taking too long with their operations? Are we not giving the best anesthetics that we should give? Is it the hospital's fault that pa-

tients go back in deeper shock than formerly, or is it the surgeon's fault? Will the American College of Surgeons answer this question in their deliberations?

Another thing. Is it the intention on the part of the American College of Surgeons to say, by inference at least, that only those men who are having experience in the large metropolitan hospitals are equipped to do surgery and that the others should forego that branch of medicine, or is this college to welcome all men in metropolis and in village with the sole credential that they are doing sound surgery? We know very well that some men in most modest environment are doing some of the best work of modern times, and that it is not alone those who have vast material who are getting the best results always. One visiting a large metropolitan charity hospital must become impressed with the fact that there is a wonderful waste as well as wealth of material.

This American College of Surgeons comes into existence with far from a universal welcome. It is on trial. Let us see whether it can justify itself in the good it can do to the world in general and to the profession of medicine. If this question is answered in the affirmative, the college will live to accomplish great things. If it is not so answered, it will not live.

JOHN A. HORNSBY.

Save the Hot Springs.

A concerted movement is being made to create a great water cure center at Hot Springs, Arkansas—something after the plan of the European "baths." For many years the curative properties of the Hot Springs waters have been recognized. The government many years ago, because the springs were being exploited by private parties and money-making syndicates, created a government reserve about and including most of the springs, woods, and hills. A few concessions have been let, since that time, under circumstances that would seem to protect the public, and the government has built hospitals for its army and navy men. The B'nai Brith, a great Jewish society, has a sanatorium there, and the Masons have already purchased ground in the city proper for the same purpose.

There are plans under consideration now by which the government is to be asked for other concessions, the Order of Eagles, the Order of Moose, and others being mentioned as making preparations for an appeal to Congress in this behalf.

In the meantime the American Medical Association, always foremost in work that concerns the public health, has been trying to obtain the creation of a government commission to study the waters of the Hot Springs chemically, physiologically, and therapeutically. This move was first made at Atlantic City a year ago. Nothing was accomplished, except that the government scientists stationed at Hot Springs began such an investigation on their own initiative. The matter was again presented at Minneapolis, and under rather tragic conditions. One of the leaders of the movement was Dr. H. M. Hallock, who wrote this year's report to the association and died just before the convention. His report was discussed at length in the Section on Pharmacology and Therapeutics, and it was agreed that pressure on the government should be renewed. Without any doubt this very necessary work will have the active support of the war, navy, and public health departments, and eventually the commission will be created and the work done.

In the meantime no irrevocable concessions should be made that would in the slightest degree interfere with future plans for a homogeneous and harmonious development of the springs by the federal government for the benefit of all the people.

The destruction of large areas of the city of Hot Springs by fire a few months ago furnishes an excellent excuse for reopening the whole question of the future of the Springs, and perhaps some radical changes may be introduced that will give back to the public a magnificent health resort.

Let us take a lesson from Germany in regard to the control of our curative waters. Baden-Baden, Neuheim, and Carlsbad have been built up as "water cures" under government regulation and restrictions, and, without taking into account the real value of those waters in the cure of disease, they have brought to Germany more visitors annually than all the beauties of the Rhine, all the art of the German galleries, and all the sciences in the famous German schools.

There may not be very much positive therapeutic virtue in hydrotherapy as a physical agent or physiologically, and we need not debate that question, but it is very certain that any great center set apart in which people can find an "atmosphere," a regimen, and restrictive living will be of untold value, just as a man in the penitentiary will get better of diabetes, and just as a patient with uncompensated heart will get better in the atmosphere and under a diet in the hospital.

This country needs "baths" and "water cures" and "springs," and, as our processes of living become more and more violent every year, the need must grow. But these retreats will be of real

curative value in proportion as they are properly controlled and regulated. The waters of Saratoga ceased to be valuable in the presence of gambling and politics. The German "baths" have been badly hurt as "rest cures" and "water cures" since Monte Carlo set up branches in their casinoes.

There are a great many water cures in this country—places to which the sick could be sent for rest, for diet, and for a regime of proper living—but we should see to it that they are kept for the sick, and now is the time and Hot Springs is the place to build a high fence of government control and ownership, and a hard and fast rule of police domination. There are enough "Coney Islands," "Venices," and "Dreamlands" for well people.

Is This the Duty of the State?

It is to be very seriously doubted whether the recently enacted legislation in many states compelling cities, towns, and counties to build and operate tuberculosis hospitals is the final and best solution of the tuberculosis problem. While it is unanimously agreed that aggressive measures are necessary in dealing with the great white plague, there is no particular reason why there should be quite so much hysterics about it, and we will get further if we employ rational means and pursue logical courses.

California is today overrun with "lungers," and the permanent population of that state is being compelled to provide for them. It is true, many of them get well, and in turn take up their part of the burden of caring for others, but a large percentage of California's population today is made up of sufferers from tuberculosis. Only the favorable climate and tremendous productiveness of the state make it possible for the well people to take care of those who come to them sick.

It is notorious that the poorest communities have the most tuberculosis, and that those least able to support hospitals for this class of sufferers are compelled to do the most.

Many parts of the country are beginning to rebel against the new mandatory laws, and the officials are finding it necessary to be very lenient in enforcing them.

The latest protest comes from Massachusetts, of all states the least likely to shirk its duties regarding the public health. Haled before a recess summer committee of the state Legislature the other day to explain why they had not complied with the law, Fall River and Lowell uttered their complaint and asserted their judgment that the law was unfair. Dr. John H. Gifford, a prominent physician of Fall River and the representative of that city's Chamber of Commerce, was the spokesman, and in a long argument he insisted it was the duty of the state to build and operate these hospitals. Lowell followed, pleading rather that the city knew its duty, and that the state should build and conduct whatever hospitals it saw fit, without compelling any part of the state to assume burdens which were too heavy, and of whose use there might be doubt, in so far as individual communities were concerned, however beneficent the law might be as a general purpose.

Freeholder John Daly, of Long Branch, N. J., has also raised the question of the justice of compelling small communities to build and conduct such an institution, whether it were needed locally or not. So far as his community was concerned, he said, it would be far cheaper to send their few consumptives to other places and pay for their keep, and he therefore refused to vote money to buy a site for a tuberculosis hospital.

In Texas the antituberculosis league is preparing to provide details under which the counties shall comply with the law passed last winter. Nobody will question the singleness of purpose and the high motives that actuate the members of the league, but the fact that they are finding such a wide variety of conditions throughout the state and so much difficulty in adjusting the law, and their own addenda in the shape of details, to these conditions, serves to emphasize the question whether these laws are wise.

Many years ago, when fewer of us were insane, and when there were fewer of us to become insane, small communities, especially cities and counties, built and conducted their own insane asylums; now Wisconsin is the only state in the Union in which the counties maintain their own asylums. There have been many excellent reasons for this adjustment of the problem of insanity, and almost exactly the same reasons will appeal to the analytical thinker as applying to tuberculosis hospitals.

Is Insanity Increasing?

Dr. W. Maule Smith, in a recent article on "The Size of Hospitals for the Insane and Feeble-Minded," in the Boston *Medical and Surgical Journal*, strikes one of the sanest and most convincing notes that we have heard in many a day touching a topic on which there has been very much hysteria lately.

"The 'tendency to dementia' ought not to be the usual issue for the majority of the insane," he says. "This tendency largely arises from our want of knowledge of exact causation and mode of treatment, and the tendency in the opposite direc-

tion can be reached only when more abundant opportunities are provided for investigation. The day is past for 'time is the great healer' to be used when speaking about the treatment of insanity; on general medical lines I venture to say there is nothing very remarkable in the majority of cases of insanity, and there is no reason whatever why this majority should not belong to the recoverable forms of disease. But so long as we remain comparatively inactive and are content to merely house and care for the sufferers, and to make no widespread effort to reach the root of the evil, so long will public bodies continue to expend money without progressive results."

The alarmist cry about the increase of insanity reminds one of the recent report of the United States Army Medical School on the subject of "Increase of Syphilis in the Army." It was found, in the course of a long series of experiments, that approximately four times as many young recruits had syphilis as was the case ten years ago. Further inquiry, however, revealed the fact that all this vast increase dated from the employment of the Wassermann and luetin tests. What had happened was better diagnosis, and not more cases.

Opportunity for Profitable Discussion.

The two series of articles, one from the Johns Hopkins Hospital and the other from Hackley Hospital, Muskegon, Mich., are beginning in this number. It is to be expected that these papers will be of immense value to the hospital people, but it is not presumed that all will agree with the proposals and with the methods in vogue in either one of these institutions. Those who disagree with either the Johns Hopkins method or the Hackley Hospital method of doing things will have excellent reasons for their belief in their own way of doing things. The hospital people will be quite as well served by a presentation of these other methods and other ideas as they will by the original papers. Therefore it is hoped that these two series of papers will bring forth a wide, active, and profitable discussion. The writers of the papers will be glad to take up any problems that come up as side issues. Let us hear from those who have ideas of their own. Nothing will help us so much as a good, live discussion.

Final Arrangement of Dr. Smith's Papers.

Dr. Winford H. Smith, Superintendent of Johns Hopkins Hospital and one of the editors of THE MODERN HOSPITAL, who has kindly agreed to give us a series of eight papers on the intimate, inside administration of a large general hospital, with special reference to the famous institution of which he is the head, has revised the schedule of these papers, and as they now appear they will occur in a better sequence than the original schedule, made by another of the editors. The new schedule, by months, follows:

December—The organization of the Johns Hopkins Hospital, showing the manner in which the hospital, the university, and medical school are all bound together by the board of trustees, the medical board, and the advisory board of the medical faculty, etc., outlining briefly the administrative and medical organization. By Dr. Norton, assistant superintendent.

January—The organization of the out-patient department. By Dr. Seem, assistant superintendent.

February—Admission of patients, history taking, care of histories, etc. By Dr. Van Norman, assistant superintendent.

March—The organization of the nursing department. By Miss Lawler, superintendent of nurses.

April—The organization and management of the housekeeping department. By Miss Crawford, matron.

May—Purchase, preparation, and service of food. By Miss Atwood, chief dietician.

June—Purchase, preparation, and distribution of drugs, medicines and medical supplies. By Dr. Norton.

July—Surgical operations and surgical dressings. By Dr. Seem.

August—Ward waste and what is done with it. By Dr. Van Norman.

Dr. Hoffman's Vital Problems.

An article by Dr. Frederick L. Hoffman, statistician for the Prudential Life Insurance Company, on the subject of the tabulation of the vital statistics of the Memorial Hospital of New York for the treatment of cancer appears elsewhere in this number. The figures Dr. Hoffman gives us and the manner of their presentation are extremely illuminating. It is such figures as these, presented in the way that these are presented, that will eventually bring us some excellent standards by which we may attack the big problems of our time, not alone in hospital and kindred administration, but problems that have to do intimately with the broadest economical affairs of this most complex epoch.

Such statistics must lead into occupational channels, into eugenics, into the perplexities of consanguinity, and into that as yet unexplored problem in this country that concerns the intermingling and intermarriage of the various transplanted peoples.

It is to men like Dr. Hoffman, with his analytical mind, that we must look for the scientific solution of these multiphase problems. These figures of his, while illuminating in themselves, really form a guide by which the rest of us may go on and prosecute the necessary inquiries.

An Efficient Worker Retires.

The resignation of Dr. A. J. Ranney as superintendent of Lakeside Hospital, Cleveland, has been announced, to take effect December 1. Dr. A. R. Warner, who has been assistant superintendent, becomes superintendent. Dr. Ranney has meant very much to Lakeside, and his administration has guided that fine institution until it is now respected as one of the best hospitals in this country. The hospital world has been greatly indebted to Dr. Ranney in many directions, and loses an able, efficient worker in his retirement. Lakeside will have the condolences of the hospital people everywhere, mingled, however, with the sincerest congratulations that so able a man as Dr. Warner is at hand to take the banner of progress laid down by Dr. Ranney. The ideals and principles that have made Lakeside what it is are in excellent keeping. May the vigor and the enthusiasm of Dr. Warner keep Lakeside ever in the front rank.

An Excellent Scheme of Intern Service.

The New Orleans Charity Hospital has set in motion an intern organization that is entitled to more than passing notice. The hospital has 1,000 beds, and there are thirty interns whose services rotate through the various branches of medicine during the two years of their incumbency. Over these interns, under the new order, are to be four resident past-interns—one to have charge of medicine, one of obstetrics and gynecology, and two of the two surgical services. These men are to be chosen by competitive examination from the outgoing intern staff, and each will retain the place for which he is chosen during the whole year. These four men are to receive $600 per year each.

This organization will doubtless give the very highest order of service to the visiting physicians, to the patients, and to the hospital, and it will, in the course of a few years, develop a group of young men of very special excellence in their respective branches of medicine.

Political Patients in Municipal Hospitals.

Recently, as the result of a political upheaval, it transpired that an investigation was made in the Cook County Hospital, Chicago, to learn whether there were "abuses of charity." It was found that many well-to-do people were being cared for there as friends of influential politicians. The same condition was found to exist at the Oak Forest Infirmary, "the poor farm." Things are better now, but it may not be inopportune to suggest that other communities may be in the same condition—the "quiet rooms" and "recovery rooms" occupied by the friends of political grafters.

Municipal hospitals all over the country are crowded. How many of the patients are "warden specials," "friends" of aldermen, and grafters from everywhere?

Hospitals and Newspaper Publicity.

Hospital boards and administrators will do well to read and think about Mr. Maul's paper on "Publicity" in this number of THE MODERN HOSPITAL. If we are to look for support from the public, moral as well as material, we must recognize the public's interest about everything concerned in hospital work, and its right to know what is going on. If there has been an accident, even a preventable one, it will not be lessened, but greatly exaggerated, by attempts at secrecy and suppression, and the hospital that frankly acknowledges the truth and deplores the facts will fare best in the public's esteem.

Even if, by a happy chance, we might be able to hide something for the moment, we cannot be sure that it will not confront us at a most inopportune time and do real damage. Better confess when the thing happens, even if the occurrence was due to your own carelessness or neglect.

Index for Volumes I and II.

Volume I of THE MODERN HOSPITAL closes with the present number, the volume consisting of the four numbers respectively for the months of September, October, November, and December, 1913. Volume II will begin with January and end with June, 1914, and each succeeding volume will consist of six numbers, or two volumes for each calendar year. It has been deemed advisable not to print in the present number an index of articles for volume I, but to print in the June (1914) number an index of articles in volumes I and II.

The Humane Limit.

Practically every city in the United States has a dog catcher, but if a movement now under way in Seattle matures, that city will be the first to have a cat catcher. The suffering felines will be fed and treated until their wounds are healed, after which it is planned to find homes for them.

The proposed innovation should eliminate many of the midnight serenades that have annoyed local residents. With a home for each cat and said feline properly housed at night, the sleep-disturbing gatherings would be far less frequent.

The question will come up for decision at a meeting of the Queen City Cat Club's officials, when the special committee will make its report, and in all probability arrangements will be made for the establishment of a cat hospital.

CURRENT HOSPITAL LITERATURE

Woman's Hospital, Melbourne. Australian Med. Journal, September 20, XIII, 280.

The number of infants born in the obstetrical department during the past year was 1401, with a mortality of 12, a percentage that was one of the lowest among similar institutions in any part of the world.

Middlesex Hospital Club. Middlesex Hospital Journal, London, 1913, XVII, October.

The objects of the club are to continue the ties and associations between Middlesex men and their old school, and to maintain a fund out of which grants are made to old students who have fallen into adversity.

Hospital Superintendency as a Specialty. Med. Times, October, 1913, XII, 311.

This editorial calls attention to the fact that the demand for trained hospital executives exceeds the supply, and suggests that medical schools give graduate courses in hospital administration. Hospital superintendency offers a splendid field to the physician with executive ability.

Liverpool's Tribute to Miss Nightingale. British Journ. Nursing, London, 1913, LI, October 11.

Outside the Central Home of the Liverpool Queen Victoria District Nursing Association, on October 2d, a beautiful memorial tablet of Hoptonwood stone from the famous quarries in Derbyshire, with sculptured panel and surrounding molding of Pentelikon marble, was unveiled by Miss Rosalind Paget as a memorial to Miss Florence Nightingale. The sculptor is J. Allen.

The Bispebjærg Hospital. S. Bang. Ugeskr. f. Læger, Kjbenh., 1913, LXXV, No. 38.

This beautiful new state hospital for Denmark is situated on a hill near the town of Lyngby, on the island of Zealand. The hospital, as planned, will consist of twelve large pavilions, six of which are so far completed. The pavilions are ranged along a central street, six buildings being on each side. They are built on a rectangular plan, one of the small sides facing the street. At one end of the street is the administration building, fronting the whole group of buildings.

The Mothers' Hospital. British Jour. Nursing, London, 1913, LI, October 25.

Princess Louise, accompanied by the Duke of Argyle, went down to Clapton to open the Mothers' Hospital of the Salvation Army, the foundation of which was laid by her Royal Highness two years ago. Mrs. Bramwell Booth warmly thanked the Princess for her presence, presenting her a memorial key. The Princess said in reply, "With this key just presented to me I figuratively open the Mothers' Home. I visited the old one and know how greatly it was needed. I wish every blessing on this new hospital, and am sure that in Miss Booth's hands it will have the most marvelous success."

The Anatomo-Pathological Institute of the Ospedale Maggiore in Milan. E. Speroni. Ospedale Maggiore, Milano, 1913, I, No. 6.

The newly erected building contains two stories, is about 150 feet square, and has a small court in the center. It stands about 60 feet from the main building, with which it is connected by a covered way. Distinct features are a lecture room, a pathological laboratory, and a pathological museum.

An American Hospital Ward in London. Hospital, London, 1913, October 18.

The French, German, and Italian communities in London are each supporting a hospital known by the names of their respective nationalities. Americans who have done much for various British hospitals have now formed a committee of well known Anglo-Americans to endow a number of beds in the London Hospital—if possible, an entire ward—to be supported by Americans for Americans in that institution.

Women as Hospital Nurses (La donna nell' assistenza immediata ospitaliera). Guicciardi. Arch. di scienza ospitaliera, Bergamo, 1913, No. 3.

In Italian hospitals male nurses are almost exclusively employed for male patients. The author considers women much better adapted to nursing the sick than men. He recommends that the Italian hospitals adopt the practice of English, German, and Swiss hospitals, where, with very few exceptions, women alone are employed as hospital nurses.

Aluminum Vessels for Cooking Purposes. Therapeutic Gazette, September, 1913, XXXVII, 631.

Dr. John Glaister carried out experiments to determine whether foods cooked in aluminum vessels set free enough aluminum to affect the body. He found that the largest amount was freed in making marmalade from lemons and oranges, but even then it was so small that no harm would have been done if the entire 2½ ounces of preserves had been eaten at one time by one person. These results confirm those previously carried out by the *Lancet*.

More Liberal Financial Assistance for the Public Hospitals (Sanierung der öffentlichen Heilanstalten). E. Hofmokl. Wien. klin. Wchnschr., 1913, XXVI, No. 27.

In Vienna and in the other large cities of Austria the hospitals and insane asylums are overcrowded with patients. The necessary buildings cannot be provided for want of means. The nurses lack the proper education because the State does not provide for schools of instruction. The author considers it the duty of the State to furnish the necessary sums for the sustenance and proper management of the hospitals.

The Kaiser Wilhelm-Kinderheim in Ahlbeck. von Niedner. Deutsche med. Wchnschr., Leipsic and Berlin, 1913, XXXIX, No. 39.

This institution was founded by the emperor for the purpose of procuring for weak children of the poorest classes of the city of Berlin a sojourn of four weeks on the seashore. The home is situated southeast of Ahlbeck on the Baltic sea. It lies in a forest, and is separated from the shore by a belt of woods about fifty yards wide. The grounds comprise about fifteen acres. The buildings, six in number, are arranged around a rectangular park, in the center of which stands a round pavilion used as a playhouse. The pavilion, with the dormitories, have cov-

ered balconies. The home receives every month 150 children (all without pay). Until now the institution has been open from May 15th to October 15th, but plans have already been made to keep it open all the year.

Temperature and Humidity in Certain New York Hospitals. Alice L. Lake. Jour. Home Economics, 1913, V, 301.

Miss Lake has recorded the temperature and humidity in six New York hospitals. The temperature is frequently too high, especially in operating rooms and children's wards, and the humidity much too low. The control of temperature and humidity, however, seems to depend much more on the efficiency of the man in charge than on the system used. In two hospitals, one with window ventilation and the other with a plenum system, a uniform temperature was regularly maintained in spite of the difference in the systems.

Garden Cities for Consumptives—A Plea for a National Scheme. J. E. Esslemont. Hospital, London, 1913, LV, November 1.

The writer's object is to bring about eradication of tuberculosis. The segregation of infectious cases is to afford safety from infection, and enable patients to continue the kind of work of which they are capable. He advocates large colonies for consumptives on garden city lines. In the majority of cases of tuberculosis the tuberculous patient must live a suitable open-air life for years, conditions that sanatoriums and hospitals do not fulfill. The work in the colony could be done by the patients, regulated by medical officers and organized to make the colonies self-supporting.

The Berlin Children's Sanatorium at Borgsdorf (Die Berliner Kinderheilstätte zu Borgsdorf). C. Birnbaum. Med. Reform, Berlin, 1913, XXI, No. 14.

The sanitarium owes its existence to a legacy of the late Professor Neumann, the noted pediatrist. The sanitarium grounds comprise nine acres, half of which consist of woodland. The institution has room for 34 children, who are selected among the poor of Berlin. Only girls from four to eighteen and boys from four to eleven are admitted. The patients are mostly scrofulous and tuberculous children, but heart, renal, and nervous diseases are also represented. The treatment is principally physico-dietetic, sun-baths, open-air halls, good food. Gymnastics and massage are among the curative agencies employed.

Hospitals from the Patients' Point of View—Some Appreciations and a Suggestion. Hospital, London, 1913, October 18.

The writer refers to "hospital noises," none of which were serious enough for complaint, except three babies in the ward. She regards children among sick adults a great disadvantage in all hospitals. The lights hung over screens prevented disturbance of the next patient. The use of the bed-pan can be greatly improved if the supply is plentiful and the patients are encouraged in their use about the same hour. She suggests firm chaff pillows for supporting the knees of the convalescent and long bed stockings to reach over the knees. Light wraps for the shoulders are preferable to closing an open window.

Private Wards in Public Hospitals—The Passing of the Abuse of Medical Charity. Editorials in the Lancet-Clinic, 1913, CX, 423, 425.

Certain features of the policy of the new general hospital of Cincinnati are discussed. There are to be no private wards, as public opinion west of the Atlantic Coast seems to be unalterably opposed to using any part of a municipal hospital for private patients. There are to be a number of isolation rooms, to which patients may be removed when they become delirious or noisy, when death is impending, or when they show suspicious signs of dangerous infectious diseases. An attempt is to be made to overcome the abuse of medical charity by making a systematic investigation into the financial condition of patients and accepting only those who are really in need of help. As soon as the patient in the ward is convalescent sufficiently to return home, though still in need of medical or surgical attention, he is discharged. If able to pay, he is referred to his family physician; if not, he is allowed to return to the clinic for treatment.

Saratoga as a Health and Recreation Resort. Simon Baruch. Med. Times, October, 1913, XII, 291.

Dr. Baruch deplores the lack of interest in hydrotherapy in this country as compared with the very active interest shown in Germany. Very few of the springs have had scientific analyses of their waters made, and most of them cater to pleasure seekers rather than to health seekers. The physicians at health resorts do not make a specialty of their work as in Germany. Saratoga Springs courts examination. The analyses of its waters was made by disinterested chemists of the State Health Commissioner's Laboratory. The rehabilitation of Saratoga Springs for health purposes has been inaugurated by the State Reservation Commission, and should spare many of our people the necessity of crossing the ocean for treatment. Saratoga should select the diseases of tissue change, such as corpulence, rheumatism, gout, dyspepsia, gastrointestinal catarrh, and allied diseases. The radioactive properties of some of the springs fit them peculiarly for the bath treatment of rheumatism and gout.

The Royal Infirmary, Hull. British Jour. Nursing, London, 1913, LI, October 25.

The Royal Infirmary is an institution especially interesting to nurses, dating from 1784, when it had 60 to 70 beds. It now has 268, with a nursing staff of 66, exclusive of the private staff of 24 nurses. The operations last year numbered 1,550, an average of nearly 30 a week. The radium treatment has been carried out with much success, the attendance being nearly 6,000 at the electrical department. The wards of the infirmary open on spacious balconies, where patients are nursed day and night, dressings and other treatment being carried on in the open. A practical point worthy of notice is the provision for scrubbing mackintoshes. The board for this purpose adjoins a sink, thereby greatly simplifying and accelerating the cleaning process. Another item worthy of note is a cupboard in the wall of the lavatories in which specimens kept for inspection are so arranged that there is ample ventilation from the outside. The size and capacity of the infirmary is indicated in an illustration.

The Field Hospital in Peace and War. H. Sheridan Baketel. Med. Times, October, 1913, XII, 301.

There were two field hospitals at the encampment at Gettysburg, one being the regular field hospital from Fort D. A. Russell, Wyoming. The hospital had six wards, each with a capacity of 18 beds. In addition, pyramidal tents were raised, giving the hospital a total capacity of 412 beds. The wards were divided into service, as in a clinical hospital. In spite of the fact that the hospital and its equipment could be transported on eight army wagons, it had medical and surgical supplies equal to any 100-bed civil hospital. The operating room, a tent about 16x12, contained an acetylene generator and lighting

outfit, a sterilizer, and complete list of instruments and accessories, so that any major operation could easily be performed. The exactness with which the problem of outfitting the field hospital has been worked out is marvelous, and could profitably be studied by civilian hospital nurses and superintendents. The army medical officer, in addition to being a physician and surgeon, must be an administrator, a commander, and have a thorough knowledge of the work of the officer of the line.

The Box Station of the New Children's Clinic in Vienna (Die Boxstation der neuen Wiener Kinderklinik). C. von Pirquet. Verhandl. d. Versamml. d. Gesellsch. f. Kinderheilk. Deutsch. Naturf. u. Aerzte, 1912, Wiesbaden, 1913, 174-185.

Children's hospitals are always exposed to infectious diseases, which the newly admitted patients bring with them. To protect the hospital from infection, a large isolation station has been erected in connection with the new Vienna Children's Clinic. It consists of two rows of six isolation rooms (boxes), separated from each other by a hall and connected on the outer side by two corridors. All the walls and doors are of glass, with iron frames, so that students and parents can observe the patients. This isolation station has proved a success in the following cases: (1) for the reception and observation of patients with doubtful initial stages, (2) for the transfer from the hospital itself of children who are suspected of having an infectious disease, (3) for the reception of patients with a double infection, (4) for the reception or transfer of such simple infectious cases for which a larger ward is not provided (sporadic cases).

The Question of Hospital Libraries (Zur Frage der Krankenhausbücherei). I. Chomse. Ztschr. f. Krankenpflege, Berlin, 1913, XXXV, No. 6.

The author holds that a modern hospital should have three separate libraries—a medical library for the physicians, a library for the nurses, and a library for the patients. A medical library is a great necessity, for there are frequently cases in a hospital where quick diagnosis and quick decision as to treatment are necessary. To apply for literature at a general medical library would in such cases be far too slow. Such a library should have an author as well as a subject card catalogue to render the literature easily accessible. The nurses' library should be kept separate from the library for patients. Many books valuable to nurses would in many cases be harmful to patients. A separate reading room is also desirable. Of highest importance is the library for the patients. The books should be well selected. A large portion should consist of light literature. An intelligent librarian with a knowledge of human character should be at the head of such a library.

The Duties of a Matron in a Mission Hospital in India. Miss A. G. Lillingston. British Jour. Nursing, London, 1913, LV, October 11.

The writer relates in pleasing style the duties of the matron and the necessity of her learning the language to lighten her responsibilities. Her duties and responsibilities are much the same as elsewhere. The conditions have greatly improved in the last ten years, parents today giving free consent to their children becoming probationers under the guardianship of the matron missionary. The nursing superintendents of India are excelling those of Great Britain, giving a conjoint examination, with a common standard of nursing education, and hastening toward the registration of European, Eurasian, and Indian nurses. The moral and missionary training of the nurses is heavy, but a splendid part of the work. The religious instruction becomes an important feature with these children of a race accustomed to thousands of years of heathenism in one scale and only a very few years of Christianity in the other. Thus the matron's life is a busy one, but very satisfactory to the writer, and one replete with great joys.

Hospital Reform in Great Britain in Medical Economics. Jour. Am. Med. Assn., November 1, 1913, IXI, 1651.

Discusses an article in a recent number of the *British Medical Journal* advocating a voluntary medical service which would be supported by the State, and which would furnish professional services at a fixed price per week. It is proposed to erect small hospitals in the outlying districts of the cities, as well as in country communities, placing them in open, healthy places, convenient to main lines of travel, allowing every physician to send patients to any available hospitals, requiring every patient to pay for his own care, and compensating every physician in proportion to his hospital attendance. The writer concludes that the public in the United States is not ready to accept State-aided medical service, but that the hospital situation is practically the same in the two countries. There are too few hospitals, the hospitals are too highly centralized, too much restricted to large cities, the distance which patients must be carried is in many cases too great, and the number of physicians having access to these hospitals is too small. The development of small hospitals in small towns and rural communities, and the substitution of a number of hospital units in various parts of the larger cities in place of a single institution of great size and cost are some of the most necessary reforms.

The Hunt Anesthetic Inhaler. Chas. S. Hunt. Internat. Jour. Surg., September 1913, 336.

Dr. Hunt presents an inhaler which offers two new features—the ability to use a gas-ether vapor sufuence in the same inhaler, and to change with very little inconvenience from the open to the closed method. It is composed of two parts—the face-piece and the neck-piece. The face-piece has a wire screen, dividing it into two chambers—a lower and an upper. There is a screw top which, when removed, allows the air space for the open method; there is also a small sliding cap to administer the ether by the closed method, and this part can be used for a chloroform mask and also for the vapor method. The neck-piece contains the inspiratory and expiratory valve, and completes the inhaler for the closed methods. The end cap, when pulled out, permits to-and-fro breathing. The advantages of the apparatus are its light weight and inexpensiveness. As there are few sliding parts to get out of order, it is suitable for hospitals. The inflated rubber face-piece is dispensed with by having a groove into which can be inserted rubber tubing or any soft material on the under surface of the mask. Using a pad made of gauze and cotton, with an opening for the nose and mouth, makes it fit any face tight enough for nitrous-oxid gas.

The Growth of Municipal Sanatoria—Their Administration, Work and Aims. Frederick J. C. Blackmore, Birmingham. The Hospital, London, September 20, 1913.

The author describes a new tuberculosis sanatorium in the outskirts of Birmingham, built in the usual modern way on the cubicle plan for out-of-door treatment. The administration, the author thinks, must be the greatest problem. The superintendent must be a medical man, with "the velvet glove on an iron hand" ideas of discipline. Of nursing, the writer says: "Efficient nursing is of great importance in sanatoria, and one must dispose of the idea

—all too prevalent—that any nursing will do. Good nursing is of as much importance in a sanatorium as in a general hospital. Nurses should be of some social standing, as, where their social position is only just above that of the domestic servant, it will be found that the discipline is lax, and that there is a tendency for them to fraternize too readily with the patients. The number of nurses required at a sanatorium depends entirely on the character of the buildings. Where these are on the cubicle system or consists largely of separate chalets, a larger number of nurses will be required than where the buildings are long pavilions, open to inspection from either end. The City Sanatorium at Birmingham is on the latter plan, and it is found that one nurse to every 8 beds is sufficient."

Hospital Construction (Krankenhausbau). F. Voggenberger. Heïlanstalt, Leipsic, 1913, VIII, No. 13.

The hospital must, by its form and construction, itself be a means of curing disease. All the old hospitals were built on the corridor system, the greatest disadvantage of which was the lack of abundant light, now considered a most important curative agent. The pavilion system was first introduced in England. This system, which permits only a limited number of patients in one room, made it possible to supply an abundance of sunlight and fresh air. During the American civil war and the later European wars it was noticed that the patients in the open barrack hospitals fared far better than those in other hospitals, and that a supply of abundant fresh air is a most important curative means. The modern hospital is a combination of the corridor and pavilion systems, but plenty of sunlight and fresh air are the chief considerations in the construction of a hospital. There is also a tendency to make the sick rooms smaller. It is true the construction costs are now greater. While in former times the costs were from $800 to $1,000 per bed, they are now $2,500 to $4,000. In modern hospital construction the architect must also apply his artistic talent. Attractive colors, agreeable forms, etc., should not be overlooked, for beautiful surroundings are of no mean value in the treatment of disease. The modern hospital is, therefore, the combined creation of the architect and of the physician.

The Fight Against Rickets as a Requirement in the Public Care of Cripples. L. Rosenfeld. Ztschr. f. Krüppelfürsorge, Leipzig und Hamburg, 1913, VI, 199-213.

A strong plea for the early care of rickets in children to prevent future cripples and at a small cost to the public to avoid expensive and often unsatisfactory treatment later in life. Based on the work of the Nuremburg Society for the care of cripples, the author summarizes:

1. Rickets is the most frequent basic cause of crippling, probably in one-third of all cases. More cripples are thus made than from tuberculosis of the bones and joints.

2. Early treatment of rickets should prevent 70 percent of these cases.

3. The cost of this treatment to the public should not be greater than 13 marks per patient per year.

4. Prophylaxis of crippled conditions following rickets is financially best accomplished by outdoor relief (ambulatoria). Where this does not exist, it is well worth while to establish it in connection with institutions for cripples if only to combat rickets.

5. Close cooperation between homes for cripples and institutions for the care of infants and children greatly facilitates the discovery of the crippled children of the community.

6. It should be specially required of outdoor relief institutions for cripples that great attention be paid to the treatment of rickets.

The London Hospital. Charles E. Barnett. Jour. Indiana Med. Assn., Ft. Wayne, 1913, VI, October 15.

To the visiting genitourinary surgeon and gynecologist the best three hospitals in London are the London, St. Peter, and Charing Cross. The London Hospital alone gives ample clinical material. Ocupying a space surrounded by ten squares, it has a record of over 237,000 patients' care the past year, requiring a large training school (over seven hundred nurses), besides subsidiary help. The plant is practically self-sustaining so far as concerns the manufacture of its own drugs, surgical dressings, and surgical, medical, and electrical appliances. The beds have large roller caster wheels, enabling the patient to be transferred to inner court open-air sun porch. Each bed has an individual locker and eating tray attachment, and the patient is enabled to manipulate it without rising from bed. A curtain does away with the unsanitary screens. The food is served in sealed containers for each ward, and, of course, is fresh, hot, and uncontaminated. Food or some kind of tea is served about every fifteen minutes, so that patients are served regularly six times a day with some variety. The Finsen ray for lepers is used on a large scale, and the patient is practically exposed to the ray the entire day. A daily exposure of twelve to eighteen months gives wonderful results. Each operating suite of rooms is independent of others, and, considering the seven suites, some impression is gained of the work done. The writer refers to Dr. Kidd, genitourinary surgeon, the successor to Dr. Harry Fenwich, retired, as a masterly operator, having good sense and courage to use American technic, and honesty to admit it is American.

Some Problems of the Institution Library Organizer in the State Hospitals. Edith Kathleen Jones, Librarian, McLean Hospital, Waverly, Mass.

In her paper before the League of Library Commissioners, Kaaterskill, N. Y., the author speaks of problems to be met in arranging libraries. Unless appointed by the state Board of Control or state Board of Insanity, the antagonism from superintendents must be overcome. There must be selected such material as will prove entertaining rather than educational to the patients, nurses, and hospital staff. It must be considered an adjunct to the therapeutic service of a hospital—a means of contributing pleasuse or at least forgetfulness of self, to an afflicted class, an employment for hours otherwise passed in idleness and dejection. To attain such an object, the light popular fiction takes preference over standard works and classics. Books in a hospital are for recreation, not for instruction, and should consist of fiction, picture books, travel, biography, light popular science, and outdoor books—those that are wholesome, and not morbid, gruesome, or depressing; good detective stories, and tales of adventure, however thrilling, if not horrible, and that do not make vice attractive. Illustrated books and those with pictures are often invaluable. The newest fiction is often called for and read, yet the old favorites remain much in demand. Light and simple stories should be provided for patients unable to make their own selection. Editions in large, clear type are to be recommended for the elderly and those with failing eyesight. The writer does not recommend complete sets of works, with the exception of Shakespeare, Scott, Dickens, and possibly George Elliott. In closing her interesting paper, she

dwells on the housing of hospital libraries. She regards a separate building the ideal arrangement. In all events, a library is to be made bright and attractive, with the contents catalogued and made accessible for the readers' convenience and accommodation. The interest and cooperation of the nurses becomes an important factor in the hospital library.

Temperature and Humidity in Hospitals. Editorial in Jour. Am. Med. Assn., 1913, LXI, 1541.

The editor claims we overlook the management while dwelling on the plumbing, heating, etc., in the construction of public buildings, and that the human brain is responsible for the working of the varied arrangements. The human individual is the only satisfactory automaton, and the control of temperature more a question of management than the system employed. From Miss Lake's article in the Journal on Home Economics (1913, V, 301) the statistics she gathered in six New York hospitals prove the above statement to be true. In one hospital with window ventilation and another with the plenum system a uniform temperature is maintained, despite the difference. One is consistently overheated, 75° and 80° F. being undesirable, and a temperature between 70° and 80° in the children's wards is debatable. It is a question if a day record of 76° F. should be allowed to cool to 57° at night. As a commentary on the placing and management of the thermostats, an operating room with a temperature of 88° F. registered 98° on the thermostat that was placed on a wall where there were steam pipes of a sterilizer. Low humidity is a rule in operating rooms. Of seventy-five records by Miss Lake, sixty-seven are between 20 and 45 percent relative humidity, a condition due to high temperatures, for outside humidity reaches far higher figures. The subjection of patients in wards or operating rooms to dry heat may be debatable. The provision of artificial humidification is the only suitable way to alter the situation. Provisions of temperature and humidity appear more dependent on the inefficiency of the man in charge than the system installed.

Report on Necessary Improvements in the Management of Infant Wards (Rapport sur les ameliorations a apporter au fonctionnement des créches d'hopital). H. Triboulet. Bull. Soc. de Pédiat., Paris, 1913, special number, 281-336.

In a special bulletin of the Pediatric Society of Paris, Triboulet reports on the necessary improvements to be made in the management of the infant wards of the children's hospitals of Paris, with a view to prevent the large annual loss of life due to infectious diseases. At the asylum of Medan for convalescent children and weaklings there is an annual loss of life amounting to 24 percent, of which 19 percent is from infectious diseases, 11½ percent from measles alone. This is imported from the Paris hospitals and it spreads among the convalescents in the asylum. He estimates for Paris the deaths of 500 children annually due to infections acquired in the hospitals, and therefore preventable by a more perfect system. The recommendations are that the infant wards, being indispensable, must receive sick nurslings, many affected with infectious diseases, but that on no account should normal children, subnormals, or dystrophics be taken. For these, other establishments must be used. In other words, puericulture and the treatment of sick children must be carefully separated. The infant ward should be under a rigorous asepsis, and cubicles furnished, with the necessary articles for the child's care, where each infant can be completely isolated, are necessary to this end. Until this ideal can be attained by existing hospitals, everything possible in the way of scrubbing, ventilation, open-air treatment, kitchen improvement, sterilization, and increase in nursing force must be attempted. The wards should be disincumbered, whenever possible, of cases suitable for the special services, such as diseases of the eye and ear, skin diseases, etc. At the Medan asylum the lazaret for pauper infants and the infirmary should each have a small isolation hospital, with individual cubicles, to prevent the loss of life now caused by infections coming from the infants' wards of the Paris institutions. Convalescent hospitals for infants (créches de convalescence) should be established in greater number. A valuable discussion by MM. Marfan, Weill-Halle, Nobécourt, Méry, and others follows the full text of Triboulet's report.

Special Hospital Prison at Scheveningen (De Bijzondere Strafgevangenis te Scheveningen). J. W. Deknatel. Nederlandsch Tijdschrift voor Geneeskunde, Amsterdam, July 19, 153-214.

This prison has been occupied since November 1, 1911, and is used for convicts who manifest physical disturbances and for psychopathic convicts. The movement to establish such an institution was started in 1890. The majority report of the committee was that the harmful and dangerous persons and the immoral and sexual perverts should be taken out of the insane hospitals on account of their disorganizing influence and be brought to a special institution, and that the undesirable ones from prisons could also be brought here. The minority report was that the criminal insane and the insane criminal should be placed in a special department of the insane hospitals.

This prison has three departments. One is a psychical ward for 24 patients and an ordinary ward for 25 tuberculars; the second is for men over 60 years, and the third is for 72 psychopathics to serve their sentence. The report for the year 1912 shows that of the 90 patients 12 were sent to the State Insane Hospital, and the balance remained in the department for psychopathics. The condition of the patients was very satisfactory, only two slight attempts at suicide having occurred, and no force or hyosine or morphia were used. Instances of attacking and destroying were few. The conditions, as compared with the conditions in the State Hospital, were much more favorable. The number of dangerous patients, with appropriate treatment, is small, as is also the number of simulations.

The speedy recovery of the prison psychosis, the detection of genuine psychosis and simulation, maintaining an equilibrium of the psychic disturbances of the inmates during their imprisonment, and preparing them for their future usefulness, are the objects of this institution. In many countries of Europe legislative bills are being introduced which will change the local status and the care of psychopathics. With the exception of England, all these bills are based on the same principle or idea, the result of the frequent discussions in international criminalist association meetings. The bill introduced in the legislative body of the Netherlands in 1911 is similar to the German, Swiss, and Austrian bills.

England followed another course. In May, 1912, a bill was introduced which must be a revelation to everyone, and which seeks to solve the problem in a very independent manner. If we make a general survey of the principal clauses of the bills introduced on the continent, it will be seen that the personal responsibility for the penal law remains as it was, if the imputation is not ex-

cluded. In the formulation a distinction is made between the biological and the psychological method. With the first a circumscription is meant whereby a few biological characteristics are given which excludes the imputation. A typical example is the old and at the same time the newest formulation of the Swiss bill: "Wer zur Zeit der Tat geisteskrank oder blodsinnig oder in seinem Bewustsein schwer gestort war, is nicht strafbar." The well-known difficulties of this formulation caused the bill of 1903, which follows the psychological method, to be introduced: "Wer zur Zeit der Tat usserstande war vernunftengemasz zu handeln, wer insbesondere zur Zeit der Tat in seiner geistigen Tätigkeit oder in seinem Bewustsein in hohem Grade gestort war, ist nicht strafbar. War die Fähigkeit des Tates vernunftsgemasz zu handeln zut Zeit der Tat vermindert, war insbesondere die geistige Gesundheit oder das Bewustsein des Tates wesentlich beeintrachtigt, so mildert der Rechter die Strafe nach seinem Ermessen." Here we notice that the idea of "vernunftsgemasz handeln" has been added, and even in that sense it can be absent or can be diminished.

The formulation of the well-known criminologist, Professor Aschaffenburg, is even more psychological. Austria and Servia have followed the conception of Aschaffenburg, and recognize not only an abolishment of the conception of an act and a possibility to determine the will in accordance with it, but also a limitation of the will.

The German conception is and remains based on the principle of the free will, and is interpreted by the determinists as being in conformity with the temper, character, and personality. There are circumstances when the will decrees are the result of intoxication, and then the free will does not exist. The "freiwillensbestimmung" is a conception which meets with much opposition, and is very difficult to apply in psychopathological cases.

The Netherland bill, in article 37, provides: "He is not punishable who was suffering with psychic disturbance or psychical nondevelopment, and is not accountable for the act." The expression "psychic disturbance and nondevelopment" is chosen in order to show that in every case there must be a certain degree of disturbance or nondevelopment, and distinction must be made between punishable guilt and moral guilt. The punishable guilt may exist when the intention (a psychological character) is present, while the state of the insanity may exclude the imputation (an ethical character). The Netherland psychopathic bill rests on the basis that the punishable guilt must exist if the judicial judge is to act. This conception is a combination of the biological and the psychological characteristics.

It is the function of the medical man to pass on all questions bearing on cases of insanity in so far as medical science can furnish data. He is to determine whether the accused is to be committed to an insane hospital, whether he can support himself in the ordinary way, whether he is able to meet all difficulties, whether he is responsible for his acts, whether punishment should be meted out, and whether appropriate treatment will be of any benefit.

Are there grounds besides insanity which a judge should consider? The English "Mental Deficiency Bill" gives an answer. Article 17 provides that this law is applicable to persons who are "defectives," to (a) those that are wandering, neglected, and cruelly treated; (b) those that are accused of an offense, inmates of different institutions, as reform schools, inebriate hospitals; (c) those that are drunkards according to the drunkards laws of 1879 and 1900; (d) those discharged as backward and epileptic children; (e) those that will not be desirable persons to procreate; (f) and those "in whose cases such other circumstances exist as may be specified in any order made by the secretary of state as being circumstances which make it desirable that they should be subject to be dealt with under this act."

Could we expect this of England, the bulwark of personal liberty? Here we do not find any biological or psychological, but plain economical, characteristics. Who are these "defectives"? Article 17, part 2, divides them into five groups:

1. Idiots—those persons in whom there is such a low degree of development of the psychic powers, from birth, that they are not able to protect themselves against ordinary physical dangers.

2. Imbeciles—those persons who can protect themselves against physical dangers, but who cannot support themselves on account of mental defect existing from birth or from an early age.

3. Weak-minded—those persons who can support themselves under favorable circumstances, but on account of poor development of the psychic powers, existing from birth or from an early age, are not able, first, to compete with normal persons, and, second, to handle themselves and their affairs with prudence.

4. Moral imbeciles—those persons who have shown from their early age some mental defect, accompanied by a vicious tendency, upon whom no punishment has any effect.

5. Psychic invalids—those persons who, through age, diminishing psychic powers, are not able to take care of themselves.

England has in the last few years surprised us with her courage in law-making—something American about it—and it has been observed already that the American penitentiary ideas will come to us by the way of England. Shall we follow England's dare? The State's commission of 1902 favored a general psychopathic law, in which not only the criminal insane are dealt with, but all. When our psychopathic law is changed or reformed into a penitentiary-psychopathic, and with it we have a civic-psychopathic law, then the reformation will have taken place. The context of the civic law must be that of the "Mental Deficiency Bill."

New Jewish Hospital Dedicated.

The new Jewish hospital built by the Independent Order of the B'Nai B'rith at Hot Springs, Ark., was recently dedicated by Governor Hays and a large gathering of distinguished visitors. The hospital, to be called the Leo N. Levi Memorial Hospital, contains 60 beds, and will be wholly free.

The building is a three-story fire-proof structure of stone, steel, and brick construction, and is modern throughout. The United States Government has something to say about everything that is done at Hot Springs, and the plans for the hospital were approved by the Government. There are five wards in the building, each of which contains 12 beds.

Cincinnati Will Write Some Notes.

The campaign of the Visiting Nurses' Association of Cincinnati to sell a ton of lead pencils is waxing warm. While there is no street or office-to-office soliciting, every part of the city is being systematically covered by a large number of committees who are working through the various organizations, societies, trades, and professions.

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Women Physicians Want to Compete in Examinations for Interns.

The reluctance of hospitals to give the woman graduate of a medical school the essential experience gained in its wards is regarded as a sex discrimination which is hopelessly old-fashioned. At the International Medical Congress attention was called to the fact that the number of women graduating from medical schools is decreasing instead of increasing in spite of the openings in sociological medical work, the medical missionary fields, school hygiene, and the other new avenues in the profession. In an editorial in the New York *Medical Journal* attention is called to the fact that one of the chief contributing causes for the diminishing number of women physicians is that the woman graduate is barred from medical practice, except in the cases of women's hospitals. As long as women are deprived of one-half their medical experience, and therefore of a corresponding degree of efficiency, the stimulus to taking the long and difficult course in medicine will not be sufficient to draw great numbers to the field, no matter what are the inducements offered in the way of positions for general research and applied hygiene. Philadelphia, which is the world's seat of medical instruction for women, and which boasts the first woman's medical college, is likely to be the scene of a revolt against such conditions. Except for the Garretson and the Samaritan hospitals, conducted in connection with Temple University, where coeducation prevails in the medical school, no hospital in the city other than those conducted by women gives women a chance to gain experience as interns. At Blackley several years ago women physicians were admitted and did effective work on the hospital staff, but recently the department of health withdrew the opportunity for them to pass competitive examinations, the reason being that there were not accommodations for them at the institution.—Philadelphia North American.

FOREIGN CORRESPONDENCE

BERLIN LETTER.

Berlin's Recent Awakening—Scientific Methods in Everything Explain Newer Hospital Progress—Increased Costs Are a Serious Problem for the Future.

Berlin, November 10, 1913.

This hospital letter-writing stunt is good fun for the man who writes the letters. It makes him see things more clearly and more carefully himself than he might otherwise, and, what is perhaps more directly beneficial, it keeps him in the house for an evening once in a while; for it is strange how good the cafès and restaurants are in the cities where the hospitals are worth while, and after a day spent with the more or less depressing features that always accompany hospital investigation there is always a desire to do a little comparative study of the cafès. The value of these letters to the reader can be only suggestive. One cannot go into detail sufficiently to make them of any direct practical importance. But if they can serve only the purpose of keeping in mind the constant idea that elsewhere people are doing things the best way they know how, it will make us strive to keep up the pace and thereby be of some little good.

We feel so new in America that when we come over here we are apt to look at certain institutions as always having existed. That is a mistake. Berlin, as it stands today, is as new a city as Chicago, and in many respects much more modern. If we look into the history of German hospitals, we will find that the growth has been a remarkably rapid one.

Going back only as far as the year 1200 in Germany, we find that notice was given out broadcast that, as sickness was a manifestation of divine wrath, it would be well for the afflicted *to burn themselves or have their friends do it for them.* The first care of the sick in Germany was undertaken by the religious orders. The first hospitals owed their inspiration to the returning crusaders, and were patterned after that of the Knights of St. John in Jerusalem.

At the end of the thirteenth century there was to be found in nearly every large town of Germany a hospital of the Holy Spirit. These institutions were due to one Guido, who founded an order with the first hospital at Montpellier in France. Many of these religious institutions were later taken over by the municipalities, who began to realize their duties toward the sick, and who extended and improved the service as time went on. Moreover, infectious hospitals were established outside the walls of the towns, and these were used at first for lepers. With the division of medical science, the State began to take an interest in the care of the sick and infirm, and so general hospitals, especially hospitals for the insane, lying in, and, in fact, all kinds of institutions which society now demanded, came to be established.

In 1796 a Berlin surgeon named Forney stated that Germany was behind all other countries in respect to her public institutions for the sick, and that reform was urgently needed. At that time there were only four hospitals in Berlin,[1] and none of them belonged to the municipality. In fact, up to 1860 Berlin had only private and State institutions. Then all of a sudden Berlin seemed to realize how bad things were and went at matters with a rush. In 1881-82 about $350,000 was spent. The first real municipal hospital was Friedrichshain, erected in 1874. This hospital was started by a gift of Fasquel, a baker, of $40,000. In the comparatively short time since there has sprung up the most wonderful municipal hospital group possessed by any city in the world.

In order to understand this remarkable municipal hospital development in Berlin, it is necessary to go a little beyond the direct scope of our subject for a moment and to seek the factor that has made Berlin the wonderful world-famous municipality that it is; for Berlin, situated as it is in the midst of a flat, dreary plain, surrounded by sand and pine trees, is a wonder. As I just said, it is a "mind-the-paint" city yet. The old and venerable cities like Cologne and Frankfort, and Munich and Hanover, rub their eyes and wonder how this new and lusty infant has outstripped them all. Everybody says Berlin can never be a great international center like Paris, or acquire the dignity or importance that ages have given to London. It is true that it does not possess the care-free lightheartedness of the former, nor the stolid lack of a sense of humor of the latter, but it keeps right on crawling up on both of these great cities, despite their disparaging remarks.

What is the secret, then, of this wonderful growth which is going on in Berlin, despite all the natural disadvantages with which this city has to contend? Read any book on government today and it will tell you. Berlin is the first city in the world in the development of municipal science. It has recognized the fact that it must be the link between the State and the individual. It requires highly trained specialists for its officials and pays them for their services. A bricklayer or a broker would stand just as good a chance getting a place on the faculty of the University of Berlin, or being called in to the Charitè Hospital to remove an inflamed appendix, as he would of getting any important position in the Berlin municipal government.

Naturally, in such a scientifically governed community one of the first considerations would be the proper care of the sick poor—or rather, I should say, care of the sick, for one of the first things that has been done is to eliminate the word "poor." There are no sick poor in Berlin in the sense we use the term. No person is treated free of charge in a municipal hospital. If he cannot himself pay, his club or approved society pays for him, for social insurance is a part of the German Government. But even if, for any reason, that fails, then the communal authorities must pay the hospital bill. One may say this amounts to the same thing as being a charity patient, but the effect on the patient is felt by the fact that he is not in a "pauper institution," as he would be in England, for instance. Moreover, only the officials know how the different patients stand financially. In the eyes of each other they are all equal, whether they are paying out of their own pocket or out of somebody else's pocket. All are supplied with exactly the same kind of clothes, which they must wear in the hospital, both for day and night use, no matter what their outside social status may be.

[1] Charitè, 1710; Asylum, 1726; Jews' Hospital, 1703; French Protestant, 1699.

Social insurance is the lever or the leaven, then, by which this condition has been brought about, because this has done away with pauper institutions, which no self-respecting middle-class workingman would enter. Moreover, it has done away to a great extent with charitable religious houses, which were not only bad in their care and treatment of the sick, but also bore the stigma of being "pauper" hospitals.

So it is, then, that in the last twenty-five years practically this modern German hospital system has been built up. In less than three decades Germany has changed from a pernicious system—whose institutions were nearly all military or naval, in that they were managed by the State and supported by the Department of War, or were loose charitable bodies supported by voluntary contributions—to the great municipal hospitals we see today.

The municipal authorities, then, in the last twenty-five years have provided the citizens of Berlin with a place to go when they are sick, just as a theater or an opera house is provided by the Government to amuse people when they are well. You buy your bed in the hospital just as you buy your ticket to Lohengrin. We are coming to the point in America where we begin to clamor for municipal ownership of public utilities, for gas and electric lights and street cars, and what not, but so far we are content to handle such of our sick poor as we must in some municipal fashion—treating them, mind you, as paupers—while those who can afford it buy their hospital beds in a "private" institution.

I am not saying that these private hospitals are not all right. They are a good thing, of course, and we don't want to do away with them any more than we would want to do away with taxicabs just because the city owned the street car lines. But the point I wish to make is this—don't forget that, even though we have taxicabs, a great many people have to ride in the street cars.

Now, having said all these nice things about Berlin's hospitals, let us be mean for a moment and see what we can find to say against them. Sir Henry Burdett, who has made a most careful study of these German institutions, brings out two facts that are worthy of consideration. First of all, their great cost is to be considered. Hospitals today are far from the simple buildings they once were. Modern construction and equipment bring the cost of these new municipal hospitals up to an average of more than $2,500 per bed. The cost of maintenance is estimated as 100 percent greater than it was twenty years ago. For all of these things the patient and the taxpayer has to pay. This matter of cost is indeed a serious problem, and already plans are in the air for establishing by some means permanent endowment funds for these institutions.

The second objection advanced by the above writer, while it might be a serious one for us or for England, is one that cuts little figure with the Germans themselves, and that is the loss of individuality and severe discipline to which patients are subjected in the German hospitals. Under the ultra-scientific methods of German treatment the patient ceases to be an individual, but is merely a human mechanism that is out of order and that must be put right. No one can possess greater power than a German professor. From his first assistant down to the lowest "diener" his staff are subservient slaves, eager to do his bidding. The patient would stand no more chance to protest against his will than would a heretic on the rack sentenced by the Inquisition. Every American physician who has attended surgical clinics in Berlin has seen patients operated on without a suggestion of an anesthetic who would be given a general anesthesia for the same thing in one of our hospitals. But the German expects this sort of treatment, and the American physician's attitude towards it usually is, "I wish we had such bully good clinical material at home."

R. L. Thompson, M. D.,
Professor of Pathology, St. Louis University School of Medicine.

HOSPITAL BUREAU'S ANNUAL REPORT.

Interesting Experiment In Purchasing Shown To Be Successful—Twenty-Eight Hospitals Now Members.

The Hospital Bureau of Standards and Supplies of New York has just issued its 1913 annual report. There are now twenty-eight hospitals in the bureau, extending along the Atlantic coast, and including the Massachusetts General hospital, Boston, and Johns Hopkins hospital, Baltimore.

The bureau was organized in 1909, with a purchasing agreement covering a few articles that it was thought might be bought better by a large group of institutions than by each one separately. Now the agreement covers sixty-five articles, including chemicals, medical and surgical supplies, kitchen utensils, china and glass ware, soaps, housekeeping utensils (such as mops and wringers, linen and cotton goods), foods (such as meats, poultry, teas, coffees, preserves, and soups), rubber goods, alcohols, whiskeys, and many miscellaneous articles.

The bureau announces in its report the entire success of the community plan of purchase, and points to the fact that the number of institutions in the membership has grown from fourteen to twenty-eight in four years.

The bureau publishes its "organization agreement" in the annual report for the benefit of institutions which might wish to join, and also its bylaws for the benefit of other localities which might think of copying the plan. The report includes also a financial statement of the year's business, which makes a most interesting group of facts.

"Public Welfare" Workers.

The people of Chicago, under the leadership of President A. A. McCormick, of the Board of County Commissioners, have decided to drop the term "Social Service" as applied to those who are engaged in work for the betterment of the poor and sick, and to use instead the term "public welfare."

The new term really had its christening on the evening of November 22 at a great dinner at the Sherman House, in which several hundred "public welfare" workers participated. Dr. Richard C. Cabot, of Boston, one of the guests of the occasion, eulogized the new phrase as expressing more than any other term he had heard used in the same connection.

President McCormick deprecated any reference to his own part, either in the discovery of the new term or in the work to which it applied. He said that it had been his experience that almost every new idea that was concerned in the welfare of the people came from some woman, and that the coinage of "public welfare," as expressive of what we have been calling social service, was a woman's work.

Some foolish "mere man" in the back part of the dining room muttered, half aloud, when the president made that statement, that "the women can vote now." Of course Mr. McCormick was thinking of nothing of the sort, because he has been lamenting for months that, while the women were given the ballot by the last Legislature for many public elective offices, the office of county commissioner was not one of these.

NEW EQUIPMENT

Mesothorium and Its Application.

The nonoperative treatment of carcinoma, myoma, and other diseases of the uterus by means of mesothorium, as practiced in the University Clinical Hospital in Freiburg, rests on the principle of the exclusive use of the γ rays. The application of this principle, therefore, demands the complete absorption of the α and β rays by means of filters in order that the pure γ rays alone may be allowed to produce their effect. The γ rays, however, constitute only the smallest fraction—scarcely 1 percent—of the total ray energy of mesothorium. Hence the assemblage of sufficiently large numbers of these rays is possible only through the use of very large quantities of mesothorium—sometimes as much as 800 milligrams. But the application of such large doses makes it obviously necessary to have filters of corresponding efficiency and reliability.

The thicker the consistency of a metal, the greater is its power of light absorption. The choice of material for the filters, therefore, lies between lead, silver, gold, and platinum. Lead is frequently used on account of its cheapness. Silver, however, though dearer, is largely preferred to lead on account of the somewhat strong secondary rays to which the latter gives rise. Gold is used only where it is necessary to employ filters of minimal thickness and great power of ray absorption—e. g., in the cervix. The density ratio of gold to lead is as 0.8:2, that of silver to lead as 1.5:2. A silver filter of 1.5 milligrams and a gold filter of 0.8 milligrams wall thickness produce, therefore, the same effect as a lead filter of 2 milligrams wall thickness. On account of its smaller diameter, the gold filter can be introduced more easily into the cervix, and is, in addition, more comfortable to the patient.

In the preparation of the various forms of filter, special attention has been paid to the desirability of approaching the object of treatment as closely as possible. In addition, therefore, to filters intended for external (abdominal) use, others of different patterns have been constructed for internal treatment from the following centers: vagina, uterus, rectum, esophagus, and larynx. Two kinds of filter—e. g., intrauterine and abdominal—can of course be employed simultaneously in order to make full use of the advantages gained by "short range" and "cross" fire.

If, however, cross fire from two contiguous capsules occurs on the skin surface, the consequent ray concentration may cause skin injuries. Hence, in the construction of the double capsule holders and the spring fasteners, special care has been taken to prevent any possibility of such exposure of the skin surface to the rays of contiguous capsules. Further, to secure protection against the secondary rays, which can also very easily cause skin injuries, the filters intended for external use are imbedded in thick muslin wrappings, while those for internal use are supplied with rubber coverings.

Such instruments embody in their construction all the precautionary measures necessary for the prevention of the dangers attendant on the therapeutical use of mesothorium.

The following illustrations show some of the instruments mostly in use for treatment of cancer of the uterus, larynx, and esophagus, as well as for the external application of mesothorium rays:

Fig. 1.

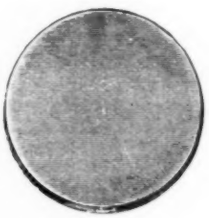

Fig. 2.

Fig. 3.

Fig. 4.

Fig. 5.

Fig. 6.

Fig. 8.

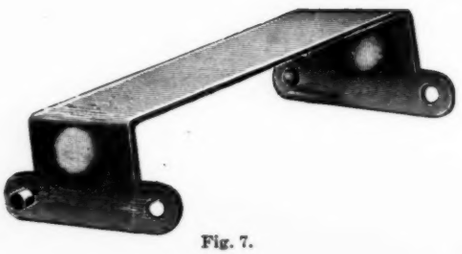

Fig. 7.

Fig. 9.

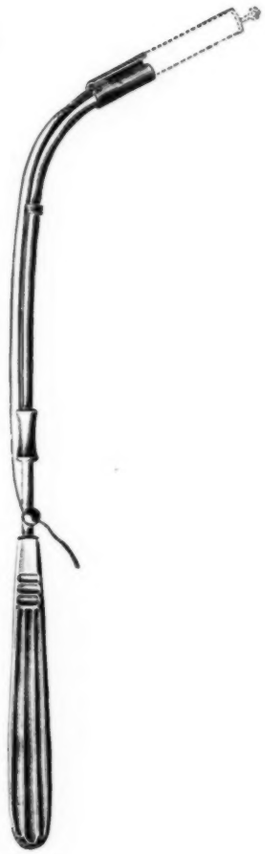

Fig. 10.

Fig. 12.

Fig. 11.

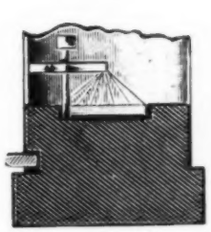

Fig. 13.

Fig. 1, flat capsule made of silver or platinum. Figs. 2, 3, ray filters made of lead from 1 to 3 millimeters in thickness. Fig. 4, holder for flat capsule and ray filters; two or more of these holders may be joined together, sufficiently far apart to avoid the concentration of the rays on the skin surface. Fig. 5, cylindrical capsule, so-called Dominici tube, made of silver; this capsule is employed in connection with the tracheal, laryngeal, and esophageal applicators. Fig. 6, cylindrical capsule for external application. Fig. 7, holder for external capsules; two or more of these may be joined together. Fig. 8, intrauterine or vaginal capsule; holders made of lead or silver, with lead filters. Fig. 9, forceps for introducing capsule holders in the uterus. Figs. 10, 11, instruments for intralaryngeal ray treatment of cancer of the throat after preliminary tracheotomy; the filter is placed in the larynx from above by the introducer; the ball of the screw top clips into the hole of the outer tube of the canula, and is then fixed there by the slot on the back of the inner tubes; the filter rests thus quite securely, being fastened below to the tracheal canula and above to the silk thread which is passed through the mouth and fastened with adhesive straps to the cheek of the patient. Fig. 12, esophageal capsule case in lead, with silk thread and 1 millimeter filter. Fig. 13, Crooks spinthariscope, an instrument for the purpose of demonstrating bombardment of the radium alpha rays, an infinitesimal particle of radium salt ejecting atoms of helium, which particle, although actually quite invisible, expels myriads of atoms, together with other emanations, every second, and this one microscopic speck is supposed to be capable of maintaining the supply for about two thousand years.

VINCENZ MUELLER.

The Dwight Operating Table.

This table, designed especially for operations on the eye, ear, nose, and throat, in its normal position stands 33½ inches high, 70 inches long, and 20 inches wide. The back section is cut out on the two sides as shown, permitting

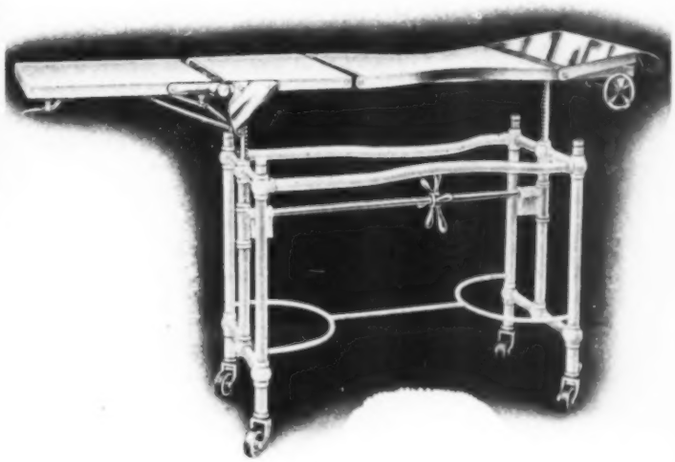

Fig. 1. Dwight operating table—normal position.

the surgeon to stand directly in front of the surgical field. The top of the table can be raised by means of two worm screws and gears, one at each end of frame, operated by means of a spoked wheel in the center of the shaft between

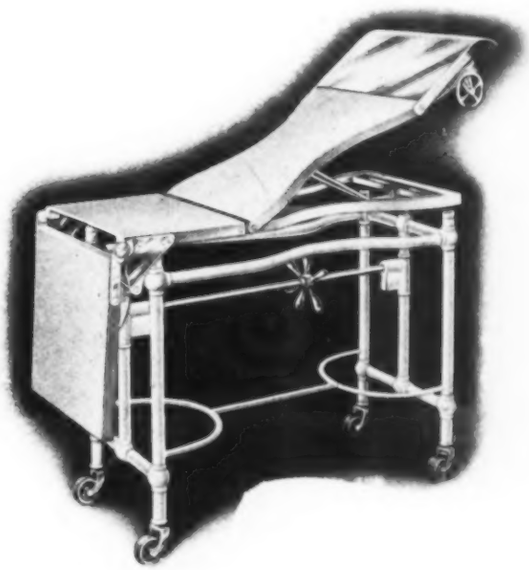

Fig. 2. Dwight operating table—back section elevated.

the gears, to a height of 10 inches above the normal height of table.

The head-rest extends across the entire width of the back section, and can be raised or lowered by means of hand wheel in connection with quick-working right-and-left screw with traveling nuts. The edge of the head-piece is shaped to conform to the curves of the head and neck.

The back section of the table is adaptable from the horizontal plane to an angle of forty-five degrees. The foot section of the table can be dropped to place the patient in a sitting position, if desired.

The table is mounted on large three-inch rubber tired casters, two of which are supplied with brakes, which, when used, make the table rigid and immovable.

The finish of the head-rest is brass nickel-plated, and the other parts of the table are white enamel.

CORYDON G. DWIGHT, M. D.,
Madison, Wis.

CONSTITUTIONALITY OF LUNACY LAWS.

Mentally Unbalanced Entitled to Trial By "Jury Of Their Peers."

The constitutionality of the law passed by the Thirty-third Legislature of Texas, providing for adjudication of lunacy by a county judge upon a report of a commission of six commissioners appointed by the judge, is questioned in proceedings for habeas corpus filed in the Court of Criminal Appeals at Austin.

This law, commonly known as the lunacy commission law, amends acts of the Legislature of 1911, and according to the contentions advanced by attorneys in the habeas corpus case of James Singleton, of Harris county, it denies a person the right of trial for his life or liberty by a jury; instead, provides that the trials of persons on lunacy charges be held before a commission of six, consisting of physicians, providing the proceedings are held in counties having a population of 50,000. This, the attorneys contend, denies him his constitutional right of trial by a jury of his peers.

If this law is held to be unconstitutional, lawmakers in many states will have to set about revising the present methods by which the mentally unbalanced may be tested for admission to hospitals for the insane. It may be hoped that this is the opening wedge leading to a more humane method of treating perhaps the most unfortunate class of sick. Public exhibition of these people in open court, to be passed upon, often by laymen, is a disgrace to our vaunted civilization.

Fitting Memorial From Children.

A movement was launched at the celebration of the sixty-third anniversary of the birth of Robert Louis Stevenson, in San Francisco on November 13, to endow a room in memory of the famous writer at the Children's Hospital in that city. The Stevenson Fellowship is at the head of the enterprise, which is said to have been suggested by Mrs. Stevenson, the writer's widow.

"Treasure Island" has delighted the hearts of probably more children than almost any other story, and it is very fitting that a memorial to a writer of such entertaining, clean, and wholesome stories should be connected with a children's hospital.

Dr. Frank E. Chapman, formerly of the Frisco Employees' Hospital, St. Louis, has been appointed superintendent of the St. Louis City Hospital.

NOTES *on* NURSING

The Grading of Nurses.[1]

By MISS MARY M. RIDDLE, Newton, Mass.

In 1893, just two decades ago, we find there was convened in the city of Chicago a body of philanthropists, reformers, and charitable workers, having a section devoted to the consideration of hospitals and dispensaries, with a subsection on nursing. Their report furnishes most interesting reading, and in the light of later-day developments many of the papers and discussions therein contained are truly prophetic.

The same pleas were made that are heard today, for we read that the obligation rests on the hospital to promote the public health by increasing and diffusing knowledge, and no hospital can be considered as doing its complete, best work if it is not contributing to the training of physicians and nurses. And "in considering standards of education for nurses we must not overlook the smaller hospitals, for they have their work to do as well as the larger institutions, but that they are in no position to offer adequate teaching experience to a woman who would become a thorough nurse is very evident."

Florence Nightingale (our highest authority) is reported as writing for that convention these words, which are among her last written, thus calling for the best: "May the methods by which every infant, every human being will have the best chance of health—the methods by which every sick person will have the best chance of recovery—be learned and practiced; may we hope that, when we are all dead and gone, leaders will arise who have been personally experienced in the hard, practical work, the difficulties and the joys of organizing, and who will lead far beyond anything we have done."

And again she says: "Nursing, proper, is therefore to help the patient to live; to teach the nurse how God makes health and how He makes disease; to teach her to observe exactly such stupendous issues as life and death, health and disease; to make her not servile, but loyal, to orders and authorities; to teach her how to handle the agencies within our control which restore health and life, in strict obedience to the physician's or surgeon's power and knowledge."

The report here quoted from is chiefly historical. It contains the present-day principle and tone, asking for better trained people as well as for more and better service to all classes of people, showing that long before the American Hospital Association was born our forbears and our superiors were making the same demands that are made today.

To their everlasting credit be it said that the first calls came from the nurses themselves, and they have continued to this moment. This whole subject of the "grading of nurses" has its origin in the desire of physicians and

[1]Paper read before the American Hospital Association, August 27, 1913.

nurses, whether organized or unorganized, to secure better nursing service for people of moderate means.

Previous efforts have been futile because they have been made with the idea of securing the best service without rendering an equivalent, or they have been attempts to adapt the best service to the possible equivalent by an adjustment of the time given, or the patient has been compelled to accept an equivalent without regard to his needs.

These failures prove that people of moderate means are satisfied, and rightly, with nothing short of the best; that, when given the best for a shorter period of time, they still remain unsatisfied; while for a longer period of time at the same rate the nurse suffers, thus setting forth anew the old axiomatic principle that you cannot get something for nothing.

In 1892 the Massachusetts Emergency and Hygiene Association undertook the training of attendants with a view to caring for chronic invalids and feeble, elderly people. They chose the name attendant for this class of nurses in order that there might be no confusion with the duties or the place of the trained nurse. In reading their prospectus one is impressed with its wisdom and foresight, for one reads that they were to be duly certified; that the prices for their services were to be limited, and were never to be as much as those of the trained nurse; that they were in no sense nurses, but were to serve where the fully trained nurse was not required.

This movement was looked upon with alarm by nurses in training as well as by those in the private duty field, but the attendants were never a large number, which was speedily reduced, for they soon laid aside their title and became full-fledged nurses, ready to compete for any kind of work. We are not aware of any published reason why their training was discontinued.

In 1895 Miss Diana Kimber wrote a paper for the *Trained Nurse*, offering a solution for the two questions, (1) "How can we secure more work for our graduates," and (2) "How can we bring skilled nursing service to people of moderate means?"

The first question was to find its answer in the solution of the second. Miss Kimber proposed a system of visiting and hourly nursing, which sounded well and was well for the same class of patients to whom the attendant was suited, but it did not bring skilled nursing service to people of moderate means for the reason that the hourly nurse, with her schedule of prices, could not earn a living wage. She found that a very sick or an acutely sick patient required so much of her time that she could not visit a sufficient number of patients to make it possible. Moreover, each patient wanted her at the same time and wanted her for the very hardest part of the day's work, proving that nothing short of the best service was sufficient, and it must be rendered at a time wholly suited to the whim of the patient.

Altogether the plan proved impracticable as a remedy for the condition which sought it, though it is now practiced to some extent by nurses who care for chronic patients and by those who do not seek to entirely provide for themselves by nursing.

The Red Cross Rural Nursing Service ought, and we believe will, assist in the solution of the problem. Its usefulness has not yet been proven, but it ought to reach to the most remote parts of our land and is the logical association upon which to depend.

The Hospital Nursing Association of Boston, to quote from its announcement, "has been formed to fill a need in household nursing hitherto unfilled in Boston—namely, to supply whatever kind of care may be required for sickness in the home, each kind so graded as to furnish the maximum of efficiency at the minimum of cost, every grade to be under the supervision of a graduate nurse." This service is to include both nursing and housework, and will be done by graduate nurses, attendants, and household helpers, according to the needs of the case.

This association has made some mistakes, but it has also done some good work, though its usefulness can hardly be said to be firmly established. Its intents and purposes are of the best. Whether it can accomplish them is now its question. It has the advantage over most other schemes in that it proposes to do its work on a business basis, as does also the new venture in connection with the Civic Association of one of Boston's suburban towns, which proposes to work under the title of "Community Nursing and Mutual Aid Association." Its plans are not altogether formulated, though it will work somewhat according to those of the Household Nursing Association. Its aim is to establish a nursing center to which those in search of care for their sick will naturally turn. In response they will be given just the kind of care needed. If an attendant is needed, she will be sent and will be under the closest supervision from the center. If a graduate nurse is required, *she* will be furnished. Instead of grading the nurses, they will practically grade the work and furnish a nurse to fit it. It can be readily seen that in practice there is a vast difference, and it lies in the fact that by this system, owing to close supervision, the attendant may be superseded by the graduate and vice versa.

The question may be raised that householders will object to so much supervision in their homes, but those who have met the situation say the contrary is a fact among the people we are seeking to serve. It is said the rich people and those having many household servants do object, but that does not concern the nursing center, inasmuch as this class can employ whom they will.

The promoters of this scheme believe that greater good may thus be done for the people they desire to reach than is possible through the establishment of a hospital and bringing the sick to it. At least they are not making the mistake of instituting the hospital and demanding new and unethical systems to maintain it, assuming that, since they are fulfilling a need, they are justified in securing, for instance, the nursing service without compensation of any kind, depending on the sensational and seemingly unanswerable affirmation that for the nurse to require such compensation, either in current coin of the realm, or in opportunities for making herself proficient in her chosen calling, is treason, because it creates a hardship for said hospital and possibly its sick.

It may be that the proposed scheme for grading nurses will result in overcoming the difficulties hitherto encountered, but, since human nature does not change on demand and is much the same regardless of class, and since fixed economic laws far outrank those of the Medes and Persians and cannot be broken without the destruction of more than themselves, it follows that we must doubt the scheme's ability, though we stand ready to extend it a most cordial welcome.

Doubtless some apparent advantages might accrue to the people we most desire to help, but would they be lasting—should we be doing the best for all the people in the long run by inaugurating a system which might eventually diminish the number of good nurses? If the old saw, "a chain is as strong as its weakest link," has any truth, then might not our chain be easily broken?

True, all people do not *need* high-priced, skilled care, though experience teaches that they are apt to think they do. Besides, who can tell that the patient may not need the best and most intelligent care before he is returned to his place in life, and can we afford the risk incurred by not giving it to him?

We all believe that the great middle class is what the world must depend on for most everything that is worth while, and therefore the world should see to it that they have the best. In this our bounden duty is evident, and we cannot in conscience repudiate any plan without serious thought.

Again, the smaller and more poorly equipped as well as the purely commercial institutions would have better reasons for their existing training schools, but would they have sufficient interest in our people of moderate means to make their prices to them accord with the service rendered? Doubtless some would. But there is no evident reason why the nurse should be sacrificed or even exploited in the procedure.

It is easy to understand that special hospitals like those for tuberculosis might be greatly benefited, but they have always been free to adopt a system to meet their needs. Let them do so now without lowering the standards for general work, for, by lowering the standards, might we not further reduce the number of really skilled nurses?

The status of the nurses' calling is somewhat precarious today, and we cannot afford to make it more so by adopting any scheme which shall make the good, intelligent, refined young woman turn from us, as she surely will if we lower our standards.

Given a young woman who, though honest and sincere, lacks breeding, intelligence, initiative, or wisdom, and the chances are she cannot be so trained that she shall be as good and useful as if she possessed these qualities or some of them. Above all, we must have the good women, and thus quiet the criticisms regarding the trained nurse, which are so prevalent and so heartrending to the well-bred, conscientious woman who knows that the critics are working a hardship in two directions—they blame the schools for turning out poor nurses, or those who do not meet the requirements, while they make it difficult for the selfsame schools to obtain good women.

We are hearing much about shortage of probationers in our institutions, but there are nurses who, having given thought to existing conditions, are somewhat exercised by the fact that too few of our graduates are willing to care for the sick in their own homes. If a growing condition of this kind exists, is it well to increase it?

Institutions, boards of health, public schools, sanitary commissions, states, cities, and public and private corporations are enticing our graduates into other fields because therein is found congenial work, though the returns are apt to be less lucrative. The work is congenial because it gives opportunity for thought and growth, and has high standards of admission to it, proving the truth of what was read before this association last year—namely, that "the general esteem in which a vocation is held increases in direct ratio with the educational standards of that vocation." Therefore we must keep up our standards to keep our places full of good women.

The overtrained nurse being extinct, or unborn, or at least nonexistent, so far as the knowledge of this writer is concerned, it is difficult to speak of her, and anything said would necessarily be merely theory; but the "so-called" overtrained nurse we know, though her title is a misnomer; she is, as a rule, the product of good, practical experience, with too little ethical instruction, which should have been first impressed on her at her mother's knee. Having been deprived of that, and lacking the sensitive organization which might enable her to realize her need, she passes through her hospital course and enters on her career outside, where she is known for her energy, general intelligence, practical knowledge, and courage in undertaking the hardest of nurses' tasks, but where she fails, or at least does not come up to the full measure of success, because she cannot always discriminate between her duties and those of the physician, or she cannot see that her duty sometimes lies outside and beyond those prescribed as the nurse's own, or she places too high a value on *her* services—that is, she is egotistical, or else she is wanting in a few or many of those fine qualities which go to make "a woman nobly planned." She is in no sense the result of overtraining, but of undertraining, and she proves that the training school cannot always supplement in three years of adult life what should have extended at least from infancy. She is infinitely better than she would have been without the hospital training, and she is a very great argument for keeping up the standards by securing good women.

The short course is dangerous, as it is nothing more than a short cut to a competency. Is it right to offer encouragement to such? It has always existed, and almost always—not always, of course—been deplored as well as deplorable. The unsuspecting applicant for admission to a nurses' training school studies the possibilities and advantages of this or that school, and finally decides on one because it has the shorter course and will consequently insure an earlier return.

In due time she takes her place as a student nurse, and also in due time she finds she has made a mistake—that it is a short course, or practically no course, because little or no attention is paid to theoretical instruction and the practical work is limited in variety. She regrets her decision, but she is told that she has agreed to spend the allotted time and therefore cannot honorably change. Perhaps she discovers her mistake during her probationary period, and may save herself if she is sufficiently sophisticated. This happens over and over again, especially in those hospitals conducted for private gain. We may think we can regulate such conditions by law, but we cannot—we never have.

Let a man or woman have the intrepidity to appear before a legislature and pray for the regulation of such a matter, and he or she will at once recognize the impossibility, for the petition will be scorned as "class legislation." That the grading of nurses would be a distinct advantage to the purely commercial hospital needs no great array of facts for proof. The shorter course furnishes a cheaper method of procuring nursing service, and therefore it is adopted. If there were some way of informing would-be nurses of the dangers of these schools, or if they could be induced to make their application through an authoritative body, like, for instance, the American Hospital Association, or if training schools could in some way be duly and widely published as regular or irregular, the results would doubtless be less grievous.

An advocate of the grading of nurses says: "We must necessarily have training schools of varied degrees of efficiency, some of which turn out nurses not properly trained." Just here lies the danger, but we rarely see it so frankly expressed. Does this writer really mean that it is right to turn out nurses who are not efficient?

Doubtless every training school does it to some extent, but only by accident. It is not a part of the plan.

We had thought it was honestly intended that each grade was to represent the best of its kind. The act of knowingly foisting incompetents on the public is most reprehensible and should be absolutely condemned. Indeed, moderate language fails to adequately express our contempt for such a system.

A writer on this subject of "grading nurses" says: "Just as there are various grades of schools from the kindergarten to the university, so will there be various grades of nursing schools." Alas, there can be no comparison here. The kindergarten pupil hopes to go on to the university, and, even if he does not, he is not, at the end of his kindergarten career, sent out into the world armed with a certificate of proficiency to deal with great questions of health and disease, life and death. Moreover, our graded nurse will not long remain in the grade where she is placed. Experience with the good, so-called, practical nurse—may her ranks increase—has taught us the truth of this statement. She is good, the public likes her, and seeks her services. She soon increases her price, and is no longer available for the middle class. We will not stop to discuss her ethics, for up to the present time she has assumed no ethical standards, and so she is not to be too harshly censured if she has met requirements all along the way; she has gained experience and increased her ability, and she is selling her services to the highest bidder just exactly as the business man is doing everywhere. She is also incidentally depleting the number in her grade and will continue to do so. She would, however, doubtless be the better for more systematic training, which should be made to fit her needs as an attendant, and should consist largely of instruction in practical work and ethics. There is great danger in half-training, and great truth in the old saying about a little learning being dangerous, as may be illustrated by the case of the nurse who, having been told that one-fourth was one-half as much as one-half, concluded that therefore 4 percent was one-half as much as 2 percent, and she doubled the dose she was to give.

The plan of training as formulated by the Community Nursing Association is to be commended in that it proposes to train its attendants for its needs, and to grant no certificate, but to be willing to say, "She did our work well and met our requirements, though always under supervision." The same plan would be dangerous in the hands of a hospital because we should soon see the attendant earning money to support the hospital, probably with no cry from the hospital against a three-year course.

There is wisdom in withholding a certificate unless it be granted under certain conditions from the state, and its value, when balanced with its danger, is exceedingly doubtful in any case. It is too easily flaunted with the idea that "I am now equal to the best."

A certificate is not merely a voucher for work well done while gaining a livelihood, but it ought to indicate that the holder has spent time and money in acquiring what it represents—that years were spent previously in laying a foundation on which to build the ability so represented.

To recapitulate, we believe the grading of nurses to be impractical because they cannot be kept in grades; that it would be a dangerous system to inaugurate because it would encourage the short-course training school in the purely commercial hospital, thus exploiting the nurses taking the training, lowering the standards, bringing discredit on the nurses' calling, and reducing the number of good women willing to take up the work.

We believe there is necessity for the attendant. She should be taught and encouraged, but unless she takes a thorough, systematic training she should not be granted a certificate.

We also believe that outside of hospitals of a certain class the necessity for such grading does not exist—at least the necessity has not been demonstrated; that in time the requirements could be met by the Red Cross Rural Nursing Service, and such other societies as the Household Nursing Association and the Community Nursing and Mutual Aid Association; that it would be wise to encourage such bodies, and quite as easy as to encourage the organization and establishment of hospitals with poor equipment and little money in remote parts of our country, thereby entailing great hardship on the people it is most desired to help, and ultimately resulting, as heretofore described, in lowering nursing standards.

It is also believed that it is within the duty and the province and the power of this great American Hospital Association to hold up the hands of every superintendent of nurses in the land who is striving honestly and selflessly to maintain high standards in her school.

We believe, also, if it can be proven that more good than harm is likely to result from the proposed grading of nurses, that it will be our duty, as it certainly will be our pleasure, to assist in its consummation, for we agree with President Lowell, who said, "We are teaching our people not only that our present patients may have proper care, but that future generations of patients anywhere and everywhere may have it."

We are ready to admit the nurses' responsibility in all matters of public health and common weal. The thoughtful and accomplished nurse of today is studying how she can advance the health of her community, and how she can best assist the mothers and sisters and daughters who are caring for their sick in their own homes. She will devote her hours and exhaust her faculties in any scheme that is proposed for their betterment if it can be proven righteous.

Lack of Training School Heads.

For a long time the lack of pupil nurses, and the too limited number of graduate nurses to supply the ever-growing demand has given great trouble and anxiety to physicians and hospital boards.

Now we seem to have come upon a time when really well-equipped graduate nurses will not assume the responsibilities that go with the hardship of the training school. This does not affect the small hospitals alone. For several weeks two large and finely equipped hospitals in the central West have been vainly looking for women to take the position of superintendent of their training schools. There are not so many of these women at best, and those who seem to be fitted in every way, by education, by training, and by possession of those characteristics of head and heart that we have come to associate with the guiding genius in the modern training school, refuse to take the places on the ground that they can make nearly as much money and at the same time enjoy more of the comforts and luxuries of life in private practice.

It is true, institution life is hard, the responsibilities are great, and usually the pay is not high. But what is to become of nursing when the best women in the profession refuse to assume the burdens?

The writer knows a training school in a 100-bed hospital in which the pupils, almost without exception, are well educated, refined, and tractable young women, who would be the best sort of clay in the hands of a good potter, and yet those girls are getting no training and they know it.

The board of trustees is hunting high and low for a proper superintendent, and up to this time without success.

Without question the leaders of nursing thought in this country would answer this query by saying that if this condition exists, hospitals will have to revise their pay rolls and pay the salaries that the newly created condition has developed.

If this is the correct answer, we shall have to go far back of this point and revise many other things, including the whole cost of hospital administration.

Age Limit of Probationers.

There has been so much nonsense preached about the necessity to accept only "mature women" into training, it is extremely refreshing to quote the following from a paper on this subject by Miss Parsons, superintendent of the training school of the Massachusetts General Hospital, published in the *American Journal of Nursing:*

"My statistics show that about 40 or 50 percent of the probationers who enter under twenty years of age are not accepted, but the statistics show also that of those accepted the percentage of honor pupils in both theoretical and practical work is very high. I would, of course, be glad if all these young women could complete a normal school or college course, but that is out of the question, and I rejoice in my young graduates and love to think how many years they have ahead of them in which to use their knowledge and to go on acquiring experience."

High Standards for Nurses.

The following is an abstract of an address by Dr. Winford H. Smith before the Cincinnati Academy of Medicine, October 20, 1913:

"I wish to speak briefly concerning that most important department—the training school for nurses. This school is a necessity, to enable the hospital to afford adequate nursing for its sick and to train nurses for the care of the sick, both in and outside of the hospital. There is no feature of hospital work which has caused more discussion, some taking the ground that all that is needed is numbers; others, that nursing is a profession and that its members are now called upon for such important work, both in private and public work, that the standards of schools, the entrance requirements, and the methods of training should be of high grade.

"Personally, I believe in the high standards. This profession is too vitally associated with the welfare of the sick, the demands made upon its members are too many, and the responsibilities too heavy to justify anything but high standards. Institutions establishing such schools should be compelled to maintain a definite standard, and provide instruction and training such as will fit the nurse for her work and which will represent an adequate return for the service given. In charge of such a school there must be a thoroughly fine, capable, well-trained woman. She should be allowed to manage the school without unnecessary interference, but always, of course, subject to the approval of the hospital superintendent and board of trustees. In municipal hospitals, particularly, it seems desirable that there be a ladies' board to advise and assist the superintendent of nurses. Such a board, if composed of the right women, will be a bulwark of strength for the benefit of the nursing school. It should be composed of educated, refined women, the representative women of the city, but should not include wives of members of the staff."

Hospital Rules for Graduate Nurses.

The following editorial, in the October *American Journal of Nursing,* seems so appropriate, and the subject seems to be so little understood by graduate nurses, that it is reproduced in full:

"A correspondent asks some questions which she wishes answered in this issue of the Journal, the first of which includes the others: Can a superintendent of nurses in a hospital set any price for a registered nurse to charge a patient when she is on special duty?

"It has always been our opinion that when a nurse enters a hospital she does it with the understanding that she is temporarily a part of the hospital staff, and that she is as much subject to the rules as if she were a permanent resident. The hospital superintendent is responsible for her work for the time being, both to physician and patient, as would be very quickly proved should the nurse by accident neglect or injure the patient, when it would be found that the hospital would be held responsible. Most hospitals have an established price which nurses from the outside are to be paid, and nurses should conform to these regulations or not accept work in the hospital."

STANDARDIZATION OF HOSPITALS.

Urgency of Some Condition in Which Efficiency May Be Measured.

The following appeared as an editorial in a recent issue of the New Orleans *Medical and Surgical Journal:*

"The field of preventive medicine in its relation to public health has grown greatly in importance in the last few years.

"Beginning with the scientific pronouncements from a few laboratories of research, and dealing only with the causes of disease, the application of the knowledge so derived has reached out into the service for public healthfulness. One disease after another has yielded the secrets of its contagiousness, and this victory has made way for the remedial agents in the cure; more than this, the discovery of preventive measures has in many cases followed.

"So it is that the importance of public medicine has grown so as to be no longer the mere field of study and application for the physician, but the public itself is concerned—domestically, commercially, and sociologically. State boards of health are organized now to meet and combat the evils of disease, and as yet their labor has been directed at the control and extirpation of diseases, commonly contagious. Most of their service has been without reference to the hospital.

"In the wider study of disease, however, the combined efforts of sanitarians everywhere must be directed at the systematic apprehension of all disease in a community, and the morbidity bears a direct relation to the incidence of disease, which is not always defined by the mortality records.

"The hospital usually affords a concentrated population, amongst which disease and its types may be plotted with a view to the general study of morbid conditions in the community. The comparative study of hospitals makes for a better and wider knowledge of disease, but there must be some basis for study, and to that end hospitals should have some basis for standardization.

"There has been a natural evolutionary trend to similarity of methods in hospital growth and administration, but until now the systems have developed from the outgrowth of individual hospital preeminence, pointing the way to better ways of doing things. Hospital growth and medical education have consistently traveled together, and there is every likelihood that this will continue. The best evidence of this may be exampled in the proposed study and investigation of hospitals by the American Medical Association.

"The work of the Council of the A. M. A. and of the Carnegie foundations in the study of medical colleges has resulted within five years in a reorganization of medical education, which has raised the standard over 100 percent in the United States.

"Hospitals, of course, may be compared with medical colleges only upon a basis of standards resting chiefly on their efficiency in the purposes for which hospitals now stand. The efficiency of a hospital must rest on its proper care of the sick—medically, humanely, and with that degree of economy which makes for public service. The variety of elements which enter the contemplation of any plan for the standards and classing of hospitals must be large and many-sided, but the proposed task should be welcomed by all hospitals organized for the public welfare and not simply existing for corporate or segregated interests."

HOSPITAL, MEDICAL *and* SPECIAL MEETINGS

President Howell's New Committees.

President Howell, of the American Hospital Association, has announced the committees for the year as given below. In addition to these appointments, President Howell has designated Dr. H. O. Collins, superintendent of the City Hospital, Minneapolis, to conduct the question drawer for the St. Paul meeting. Under Dr. Howell's conduct the question drawer was one of the best features of the Boston meeting, and the new president intended to resign a work in which he was deeply interested into the hands of one whom he felt would bring it into even fuller fruition.

Executive Committee and Committee on Local Arrangements—Dr. A. B. Ancker, superintendent City and County Hospital, St. Paul, Minn.; Dr. Lewis B. Baldwin, superintendent Minnesota Hospital, Minneapolis, Minn.; Mr. G. W. Olsen, superintendent Swedish Hospital, Minneapolis, Minn.; Dr. Herbert O. Collins, superintendent City Hospital, Minneapolis, Minn.; Mrs. Sarah Knight, superintendent Asbury M. E. Deaconess Hospital and Home, Minneapolis, Minn.

Membership Committee—Dr. Lewis B. Baldwin, superintendent Minnesota Hospital, Minneapolis, Minn.; Dr. George W. Sinclair, superintendent General Hospital, Winnipeg, Manitoba; Dr. D. L. Richardson, superintendent City Hospital, Providence, R. I.; Dr. Jos. C. Johnson, superintendent All Saints' Hospital, McAlester, Okla.; Mr. Chas. R. Mason, superintendent City Hospital, Memphis, Tenn.; Miss Rachel A. Metcalfe, superintendent Central Maine General Hospital, Lewiston, Me.

Committee on Constitution and By-Laws and Committee on Development of the Association—Dr. S. S. Goldwater, superintendent Mt. Sinai Hospital, New York, N. Y.; Mr. Reuben O'Brien, superintendent Manhattan Eye and Ear Hospital, New York, N. Y.; Mr. Daniel D. Test, superintendent Pennsylvania Hospital, Philadelphia, Pa.; Dr. C. Irving Fisher, superintendent Presbyterian Hospital, New York, N. Y.; Rev. A. S. Kavanagh, D. D., superintendent Methodist Episcopal Hospital, Brooklyn, N. Y.; Dr. Herbert B. Howard, superintendent Peter Bent Brigham Hospital, Boston, Mass.; Mr. Richard P. Borden, trustee Union Hospital, Fall River, Mass.

Auditing Committee—Mr. J. B. Draper, superintendent University Hospital, Ann Arbor, Mich.; Mr. J. R. Coddington, superintendent Polyclinic Hospital, Philadelphia, Pa.; Dr. Chas. D. Wilkins, superintendent Charity Hospital, New Orleans, La.

Nominating Committee—Dr. John M. Peters, superintendent Rhode Island Hospital, Providence, R. I.; Mr. O. H. Bartine, superintendent Hospital for Ruptured and Crippled, New York, N. Y.; Dr. Freeman A. Tower, superintendent Burbank Hospital, Fitchburg, Mass.

Publication Committee—Dr. H. A. Boyce, superintendent Kingston General Hospital, Kingston, Ontario; Dr. E. H. Young, assistant superintendent Rockwood Hospital, Kingston, Ontario; Dr. J. N. E. Brown, superintendent Detroit General Hospital, Detroit, Mich.

Committee on Hospital Efficiency, Hospital Progress, and Hospital Construction—Mr. Louis R. Curtis, superintendent St. Luke's Hospital, Chicago, Ill., Hospital Construction; Dr. R. J. Wilson, superintendent Health Department Hospitals, New York, N. Y., Hospital Finances and Cost Accounting; Dr. C. K. Clarke, superintendent Toronto General Hospital, Toronto, Ontario, Medical Organization and Medical Education; Mr. John Wells, superintendent Later Day Saints' Hospital, Salt Lake City, Utah, Efficiency and Progress; Mr. Chas. B. Grimshaw, superintendent Roosevelt Hospital, New York, N. Y., and Mr. F. C. Townsend, trustee S. R. Smith Infirmary, Staten Island, N. Y., Hospital Accounting.

Special Committee on Bureau of Hospital Information—Dr. Winford H. Smith, chairman, superintendent Johns Hopkins Hospital, Baltimore, Md.; Dr. S. S. Goldwater, superintendent Mt. Sinai Hospital, New York, N. Y.; Dr. Henry M. Hurd, secretary Johns Hopkins Hospital, Baltimore, Md.; Dr. John O. Skinner, superintendent Columbia Hospital, Washington, D. C.

Committee on Noncommercial Exhibits—Miss Lydia H. Keller, superintendent Cobb Hospital, St. Paul, Minn.; Dr. A. W. Smith, superintendent Hartford Hospital, Hartford, Conn.; Miss Harriet Hartry, superintendent St. Barnabas Hospital, Minneapolis, Minn.

Committee to Memorialize Congress to Place Hospital Instruments on the Free List—Rev. Geo. F. Clover, superintendent St. Luke's Hospital, New York, N. Y.; Rev. A. S. Kavanagh, D. D., superintendent Methodist Episcopal Hospital, Brooklyn, N. Y.; Dr. J. N. E. Brown, superintendent Detroit General Hospital, Detroit, Mich.; Dr. W. L. Babcock, superintendent Grace Hospital, Detroit, Mich.; Dr. W. H. Smith, superintendent Johns Hopkins Hospital, Baltimore, Md.

Committee to Consider the Grading and Classification of Nurses—Miss Charlotte A. Aikens, 722 Sheridan avenue, Detroit, Mich.; Miss Emma A. Anderson, superintendent New England Baptist Hospital, Boston, Mass.; Miss Ida M. Barrett, superintendent Union Benevolent Association Hospital, Grand Rapids, Mich.; Dr. R. W. Bruce Smith, inspector of Provincial Hospitals, Toronto, Canada; Dr. Wm. O. Mann, superintendent Massachusetts Homeopathic Hospital, Boston, Mass.; Dr. R. R. Ross, superintendent Buffalo General Hospital, Buffalo, N. Y.

Committee to Study the Character, Cost, and Value of Direct and Indirect Work for the Prevention of Diseases Now Conducted by Hospitals and Dispensaries, to Arrange in the Order of Their Importance and Practicability Successive Steps for the Extension of Such Work, and to Prepare Methods for Its Financial Support and for Its Correlation with the Similar Work of Other Agencies, Public and Private—Dr. J. A. Hornsby, Tower Building, Chicago, Ill.; Dr. W. L. Babcock, superintendent Grace Hospital, Detroit, Mich.; Mr. Sidney E. Goldstein, director Free Synagogue, New York, N. Y.; Miss Charlotte A. Aikens, 722 Sheridan avenue, Detroit, Mich.; Mr. Michael M. Davis, Jr., director Boston Dispensary, Boston, Mass.

Special Committee on the Inspection, Classification, and Standardization of Hospitals—Dr. J. A. Hornsby, Tower Building, Chicago, Ill.; Dr. Henry M. Hurd, secretary Johns Hopkins Hospital, Baltimore, Md.; Dr. Frederic A. Washburn, administrator Massachusetts General Hospital, Boston, Mass.

Committee on Out-Patient Work—Mr. Michael M. Davis, Jr., director Boston Dispensary, Boston, Mass.; Dr. Andrew B. Warner, assistant superintendent Lakeside Hospital, Cleveland, Ohio; Dr. Joseph B. Howland, assistant resident physician Massachusetts General Hospital, Boston, Mass.; Dr. Willis G. Nealley, superintendent Brooklyn Hospital, Brooklyn, N. Y.; Dr. R. B. Seem, assistant superintendent Johns Hopkins Hospital, Baltimore, Md.

Special Committee to Consider Suggestions Made in Mr. E. P. Haworth's Paper on What the American Hospital Association Can Do for the Hospitals of America—Mr. G. W. Olsen, superintendent Swedish Hospital, Minneapolis, Minn.; Dr. J. W. Fowler, superintendent City Hospital, Louisville, Ky.; Mr. E. P. Haworth, superintendent The Willows Maternity Sanitarium, Kansas City, Mo.

Committee on Legislation—Dr. Wayne Smith, superintendent Harper Hospital, Detroit, Mich.; Dr. George O'Hanlon, superintendent Bellevue Hospital, New York, N. Y.; Mr. A. W. Weismann, superintendent Hahneman Hospital, New York, N. Y.

And Now Comes a Bird Hospital.

New York has a woman bird doctor who maintains a hospital exclusively for her feathered patients, where she undertakes the most delicate surgical operations and treats them for every ill known. The doctor, Miss Virginia Pope, not only has found this hospital profitable, but has been compelled to construct an annex, and she cares for many of the rare specimens from the aviaries of the rich.

NEWS *of the* HOSPITALS *and* SANATORIUMS

The British Medical Association is all but disrupted on account of Lloyd-George's panel law providing for the medical care of the poor of Great Britain at greatly reduced rates. The association, as a body, fought the enforcement of the law, which was put into effect notwithstanding. Immediately the great bulk of the profession switched over, leaving the association in a most unenviable plight. Members are now deserting on the ground that the association had shown unwise leadership, and was therefore incapable of protecting the profession.

Sibley Hospital, Washington, D. C., is to receive the benefit of a general canvass for financial aid undertaken by the graduate and student nurses of the institution, and in charge of Dr. William H. Wilder, its superintendent. This appeal, which is to extend through the month of November, is the first made by the hospital in twenty years, and will be devoted to extensive improvements. No appropriation from Congress has been received since the founding of the hospital in 1894, and the work, much of which is charitable, has been carried on through individual generosity.

Muhlenberg Hospital, of Plainfield, N. J., opened a new 50-bed private pavilion on November 28, with effective ceremonies and a reception to "town and county officials and the medical and journalistic professions." The new building is a very beautiful three-story and basement edifice, of tapestry brick, simple but very dignified. It is well arranged, as viewed from the plans, and is equipped with the most modern apparatus.

The Muhlenberg group now contains eleven handsome buildings, but the best thing about the hospital is its efficient personnel, beginning with a group of trustees who realize that a board, to govern, must be informed. The board's inclusion, in the invitation to their opening, of the "journalistic profession" shows that it courts proper publicity and knows how to go about getting it.

England's Tuberculosis Dispensary.

Birmingham has always been a city in which the importance of linking up the various health agencies and after-care organizations has been recognized. The latest addition to its preventive work, since after-care must be included in that term, is the new tuberculosis center and city analyst's laboratory, says the London *Hospital*. It consists of a waiting hall, with consulting, inoculation, and dressing rooms for both sexes and a joint dispensary on the ground floor. The upper part of the building is occupied by Mr. J. Liversege's laboratory as city analyst. The aim, of course, of the center is preventive and consultative work. It will be a center for the examination of "contacts" and a general information bureau open to every citizen. As a center for educational propaganda also it is hoped to do much good work, and during the winter there is a project for holding a course of lectures to patients and their friends. At the present time—for part of the institution has been in use for some six months—900 patients a week are being dealt with. Few things have been more remarkable in institutional development of late years than the way in which the dispensary has grown from a single department into a unit embracing educational, consultative, and specialized branches. The dispensing is now only one part of what is virtually a new institution which the word "center" not inaptly describes.

American Ward in London Hospital.

The French, German, and Italian communities in London each support a hospital known by the names of their respective nationalities; but hitherto the Americans, more numerous and more affluent, probably, than any other visitors, have done nothing in a corporate way toward hospital work and support. As a matter of fact, Americans have done a lot for various of our British hospitals in which they are interested, and it would be quite erroneous to suppose that they are less generous or less charitable than the Continentals. The very nearness of their kinship with us renders them so much less strangers in our midst than those whose speech is alien, that a special hospital run by Americans is certainly not a pressing need. There is, however, no doubt that some appeal to American pride of race would be a powerful aid toward creating an interest in the work of our hospitals, and that it might induce many to subscribe who hitherto have not done so. Obvious as this sounds, now that someone has had the happy thought and translated it into deeds, we must not fail to give the credit of it to its originator, whose name has not transpired. At any rate, the good idea has resulted in the formation of a committee on which many well-known and representative Anglo-Americans will serve, and it has been decided to endow a number of beds in the London Hospital (if possible, an entire ward), to be supported by Americans for Americans in that institution. Mr. R. P. McGrath, of the London Hospital, is treasurer, and Mr. J. P. Coughlan, Walter House, Strand, secretary of the movement, to which we wish every success. Incidentally, we may felicitate the London Hospital also on the additional strength which the arrangement is likely to afford it.—The Hospital, London.

Continuous Service of Medical Staffs.

President Howell, of the American Hospital Association, has sent out a letter making an inquiry of hospital superintendents concerning medical staff service. He wishes to hear from all hospitals on this point. Dr. Howell's letter follows, and it is hoped that every superintendent will reply promptly, telling whether the staff service is continuous or intermittent. The president will be grateful for information concerning any special features of staff organization in any hospital.

"I desire to ascertain how many hospitals there are in this country which provide continuous services for their attending staffs. I am writing to ask you if you will furnish me with a list of all the institutions you know of which provide such service.

"Very truly yours,

"THOS. HOWELL."

Mr. Michael M. Davis, director of the Boston Dispensary, was the principal speaker at a meeting at the Academy of Music, Brooklyn, on November 11. A campaign is being inaugurated by the Brooklyn Institute to educate the public to the needs of social service.

QUERIES *and* ANSWERS

The Use of Ether.

To the Editor of THE MODERN HOSPITAL:

I am writing to ask what ether you advise for anesthetic purposes? The Squibb ether has been used here almost entirely, but there is so much difference in the price of this and the Mallinckrodt that I am anxious to know about it, both from the standpoint of safety and economy, and shall be glad of any information you can give me.

IDA B. VENNER,
Superintendent Passavant Memorial Hospital, Jacksonville, Ill.

The hold that Squibb's ether has on the medical profession is due to conditions now long gone by. There was a time when Squibb's ether was the only reliable ether on the market. Now there are other ethers that are quite as good and much cheaper, notably the one you mention, Mallinckrodt's. Two or three years ago I made some exhaustive tests with these two ethers in the Michael Reese Hospital. The tests were undertaken on account of the great difference in price between the two, and because the surgical staff declined to use any but Squibb's unless some definite showing could be made. In these tests, which were carried on in the chemical laboratories of the institution, it was shown that the purity, strength, evaporation, etc., were identical, and that the invoices of Mallinckrodt from month to month held remarkably true. Since that time Mallinckrodt's ether has been used exclusively and satisfactorily. Most of the large eastern hospitals use either Mallinckrodt's or both indifferently.

JOHN A. HORNSBY.

Floors for Tuberculosis Hospital.

To the Editor of THE MODERN HOSPITAL:

As a subscriber of your journal I am writing to you for some information in regard to the best kind of floors to be used for a tuberculosis hospital. I have had several experts advise me to use wood floors for the reason that patients can obtain more comfort from wood, that it is not so cold or tiresome, and is warmer in cold weather and cooler in hot weather. I also find several hospitals covering the tile or composition floors with wood for the same reasons. If you will kindly furnish me with your best judgment in this matter I will appreciate it.

EDGAR P. MADORIE,
Architect, Kansas City, Mo.

There is no doubt that tuberculosis patients will be peculiarly susceptible to the influence of cold tile, concrete, or composition floors. They have a temperature as a rule, chill easily, and "catch cold" quickly. On the other hand, tuberculosis bacilli enjoy the dark and usually moist and dirty cracks in wood floors, and these floors are almost prohibitive on this account, even if it were economically possible to keep them clean and nice appearing, which it is not.

I am very much impressed with the value of battleship linoleum, especially for the purpose indicated by the inquirer. In six-foot widths, cemented to the floor all over, and not just around the edges, and set flush with the edge of the rounded cove base all around the room, I cannot conceive a better floor. It can be waxed or varnished after it has set well—after a year on the floor, for instance—and small rag rugs can be used when patients' feet are to rest for any length of time, at the bedside and out in the floor where the chairs will be. These rugs can be sterilized, boiled, or sent through the laundry washers when necessary.

Cheap Thermometers.

To the Editor of THE MODERN HOSPITAL:

How cheap may one buy clinical thermometers and still feel that one has a right to expect that they will be accurate? We have recently been offered thermometers so cheap that we are afraid of them. T. W. A.

Why not make accuracy your guide instead of price? Any thermometers you buy should have previously been tested. You had better not accept thermometers that are "off," even though the variations are registered on the slip that accompanies them, because the slip gets lost and the ownership of the thermometer changes from one nurse to another, and the variation is forgotten. It is best to test your thermometers when they are received, in spite of any guarantee. Keep one absolutely accurate thermometer for a control; place a dozen at a time, including the control, in water at about fever temperature; stir the water gently to insure uniform temperature; leave them in just the time they are gauged for; if they are "three-minute" thermometers, leave them in exactly three minutes; those that have not registered in the proper time are dangerous because nurses are not expected to wait longer. Reject and return all that show variations.

But this is not enough; thermometers have been known to register properly for a month or longer, and then, because of some slight defect in the glass or the mercury, or the making, go "off." About once a month every thermometer in the house should be exchanged "for a new one." This will give an opportunity for the head nurse to test all over again. This exchange day for thermometers should be just as much a part of the nursing technic as any other procedure.

Sterilizing Rubber Gloves.

To the Editor of THE MODERN HOSPITAL:

What do you consider the best, surest, and easiest way to sterilize rubber gloves? Our surgeons demand so much heat, persisted in for so long a time, that our gloves go to pieces in three or four usings.

J. W. H.

I think we have been growing rather hysterical about the sterilization of rubber gloves. A good test of this fact is that, if you compel surgeons to pay for their own gloves, they are satisfied with far less heat and a less destructive process, than where the hospital gives them all the gloves they ask for without expense to them, and yet it may be assumed that in either case they will insist on a thorough job.

If gloves are well cleaned in hot water and green soap, and are then put into hot water at a temperature of 180° F. for forty-five minutes, they will be absolutely sterile unless they have been handling one of the spore-forming microorganisms, such as tetanus or the gas bacillus, in which case they will have to be boiled at 212°F. for an hour. This last process is very destructive of rubber. Most hospitals run their gloves through the dressing sterilizer (vacuum) 10—20—10, with the dressings. The drying part of this process is terribly hard on rubber, and I think it is wholly unnecessary according to the rules laid

down for the death point of the pathogenic microorganisms.

It seems to me that the sterilization of the gloves is a far simpler problem than that of maintaining sterility after they are heated and until they are used again. You may sterilize all you please, but, unless you keep them sterile afterward until used, what is the advantage? I have been thinking recently of a sterile waxed envelope in which they can be kept sealed. They can be powdered with sterile talc before sealing.

JOHN A. HORNSBY.

Temperature of Water in Rubber Bottle That Will Burn Patient.

To the Editor of THE MODERN HOSPITAL:

How hot must water be in a rubber bottle to burn a patient? A child in our hospital was burned during the "sleep" after operation. The nurse, corroborated by the house physician who was helping her fill the bottles, declared the water was at a temperature of 110° F. before it was poured into the bottles, and it must have cooled at least a little during the process. Some of the doctors insist the temperature must have been higher.

J. W. G.

There is no doubt that water at 110° F. will burn a child under the conditions you have named, especially if there was pressure under the bottle sufficient to have still further lowered the blood supply to the part. It is not so much the temperature of the water as the stasis of tissue at the site of the bottle that permits the burning. If there is a good, free blood supply to the part, pretty high temperatures will be borne without injury, even in the case of a child. The blood, passing through, flushes the part, always bringing in cooler blood to replace that which has been overheated and to cool the solid tissue. This can be, and often has been, illustrated in irrigating the vagina with hot water. Water at even 140° F. can be used without any worse result than temporary discomfort, provided there is no speculum or retractor in at the time; but put in a speculum and exert pressure, so that the blood supply under it is cut off during the process, and water at 115° F. will make a bad burn at the point of pressure. This is precisely the principle at work when patients with "low vitality," or patients just returned from the operating room, are burned. It is a question of poor and sluggish blood supply, and an absence or sluggishness of the flushing process—pressure at the point, or weak driving power behind the blood stream.

Metal bottles burn at a lower temperature than rubber because of better conductivity of heat, and a thickness or two of flannel or coarse cloth has saved many a patient. But the pressure is the main cause of burns; that is why nearly all burns are located where the patient has rested on the bottle.

A hospital superintendent who had been allowing the medical staff to prescribe from 6 to 8-ounce bottles of medicine for patients without protest, persuaded the staff itself to make a rule cutting amounts down to the actual, immediate needs of the case, and he cut his bills for medicine in two the first month. The same rule provided that no proprietary medicines or medicines that come in sealed packages should be ordered without special arrangement.

The chief advantage of these two rules was in persuading the medical staff to put the check on itself, instead of having the initiative come from the administrator. The men really take a pride in enforcing their own rule, while they would have fought its enforcement, at least indirectly, if they had been coerced into it. But the saving was well worth while.

HINTS FOR HOSPITAL SUPERINTENDENTS.

When the prison warden of the American penitentiary is a hospital administrator who has had the ripest training in psychiatry and psychopathology, and when the turnkey's salary is being drawn by the hospital pathologist, the self-satisfied people of our country may begin to feel that we are really getting somewhere.

A hospital that has been using a barrel of alcohol a month cut the amount down to a barrel for four months by giving the nurses a 20-percent alcohol for rubs instead of 60-percent. The rubbing is the thing that does the most good in alcohol rubs, though the alcohol has great cleansing power and helps greatly to prevent bed sores.

Don't buy short-fiber floor mops. They are made of waste bits of cotton, and leave their trail in the shape of dirty strings wherever they are used—in corners, on casters, table and chair feet, on radiator legs, and even on the walls. These short-lived mops cost on an average 25 cents each, while a long-fiber, well-knit twine mop costs 50 cents. The latter lasts at least eight times as long as the former and leaves no trail behind it.

Rough cement floors painted red are worse than useless. They clean badly, always look dirty, and hold microorganisms of all kinds in the fine blowholes and interstices. These floors are all right for many places, but they should be, as soon as laid and before workmen have had time to grind dirt into them with their heels, covered with an approved waterproof cement paint tinted the color you want. The carbolithic and other composition floors should be oiled with boiled linseed oil about once a week until they will not absorb any more, after which they can be kept clean and will be impervious.

Some of the most economical practices in hospitals are the most expensive. Take the item of paint. Cheap paints come very high in the long run; it costs just about as much for labor as it does for enough paint to go over a room or a corridor. If you use a paint that will last a year, it will cost a little more than one that will wash off with the first soap and water, but the labor will be only half as much.

Don't permit your board of directors or any member of it to give orders to your subordinates. Boards are disposed to do this without realizing that the first result of it will be subversion of all discipline, quickly followed by inefficiency in your own efforts to control people and things; the final outcome will inevitably be your failure as a superintendent, and a necessity on their part to get some one else, notwithstanding the fact that you could have made good if they had given you a chance. Your duty to the hospital is to protest to your board if they go over your head to deal directly with your subordinates; explain just why you object to it, announce your willingness to take orders from the board at all times, and to be held accountable by the board for whatever transpires. If they insist on their right to give orders to others than you in the hospital, it is your duty to yourself to resign before you have become a failure and are dismissed as inefficient.

A tuberculosis sanatorium is to be built at Silver City, N. M., by the Methodist Episcopal Church of the United States.

A NOTABLE WORK ON STATISTICS.

Bulletin of Johns Hopkins Paves Way for New Era in Hospital Data Efficiency.

The need of better hospital statistics has for many years been recognized by all who are familiar with the facts, and who, for professional or other purposes, are required to make use of the more or less inadequate information at present available. It is lamentably true that this important field of statistical research has been almost completely neglected, not only by those in charge of hospitals and allied institutions, but also by the medical profession. Of thousands of institutional reports published annually in the United States, only a few contain an intelligent, practically useful, and scientifically comparable statistical account of the experience reported upon. The Johns Hopkins Hospital, in this respect, has from its establishment been a notable exception, and the facts published annually have been most useful, not only to the medical profession, but also to the laity interested in the results of hospital treatment. In appreciation of the general scientific utility of the Johns Hopkins Hospital statistics, Mr. Frederick L. Hoffman, the well-known statistician of the Prudential Insurance Company of America, has subjected the published material for the last twenty years to a thorough critical analysis, first presented in the form of an address before the Johns Hopkins Medical Society, and now printed, with numerous additional tables and diagrams, as one of the bulletins of this well-known institution.

The monograph by Mr. Hoffman is practically a treatise on hospital statistics, and a guide to the statistical methods which should govern in the annual publication of hospital reports. The discussion is chiefly limited to the medical and surgical statistics of the hospital, and does not include a critical consideration of hospital accountancy, etc. After pointing out the practical utility of hospital statistics to the medical profession and the laity, and the imperative need of uniformity, the author briefly considers the problem of morbidity, both general and institutional, and the closely allied subject of nosography and the public registration of diseases. By correlating the statistics of admissions according to age, sex, and principal diseases, or nonpathological conditions on admission, to the population of Baltimore, according to sex, age, and race, the relative importance to the community of each factor is established, at least with approximate scientific accuracy. The value of this method, which is entirely new in hospital statistics, is best illustrated in the statement that, in proportion to population, the general admission rate to Johns Hopkins Hospital for the decade ending with 1911 was 79.9 per 10,000 for white males, 70.4 for white females, 99.9 for colored males, and 135.4 for colored females. For both races and sexes combined the aggregate admission rate was 81.8. This rate is based on 44,263 admissions to Johns Hopkins Hospital during the decade ending with 1911.

The discussion of the admission rates according to population properly includes observations on the probable number of admissions to institutions other than Johns Hopkins Hospital, and the observed variations in the death rates of the white and colored as well as the institutional mortality generally, which is calculated on the basis of the resident white population, have been 16.7 per 10,000 of population, and of the resident colored population, 32.6. The institutional death rates of nonresidents in Baltimore were 7.0 per 10,000 for the whites and 8.3 for the colored. These rates are based on the decade ending with 1910.

There are seventy-two tables appended to the discussion, divided into eight sections, following a summary table of statistics of patients treated, with recovery and mortality data for the twenty years ending with 1911.

The first section, consisting of eleven tables, shows the general statistics for white patients, differentiating medical, surgical, gynecological, and obstetrical cases, and seven specified divisional periods of life.

The second section gives the same information in corresponding detail for the colored patients.

In the third section the admission rates are in proportion to population and according to color, sex, condition on admission, and method of treatment, whether medical, surgical, gynecological, or obstetrical.

The fourth section, in eight tables, exhibits the percentage distribution of admissions by causes, and also according to color, sex, etc.

The fifth section shows the summary of admissions and mortality by causes of white patients in four tables, and in three additional tables the information in complete detail for every cause, alphabetically arranged in conformity to the Bellevue classification of diseases. This is followed by a brief table of obstetrical cases for the period of 1904-1911.

The sixth section shows the corresponding information for colored patients. These two sections combined constitute the most important portion of the work, and they represent an almost inconceivable amount of labor involved in the original rearrangement of the data and the calculation and verification of many thousands of fatality rates. The tables would have been increased in value if recovery rates had been given, but, since the term itself is rather indefinite, in the absence of subsequent verification of results the author limits himself to a statement of ascertained facts. The tables, however, are not limited in their usefulness to the fatality rates shown, since naturally in the case of a very large number of diseases no fatalities occurred, but of much greater value is the concise exhibit of the actual distribution of institutional morbidity in the case of a representative hospital in a representative community, with due regard to the elementary factors of age and sex, and method of treatment—that is, whether medical, surgical, gynecological, or obstetrical. As an illustration of the amount of labor involved in a tabulation of this kind, we have ascertained the number of separate diseases or nonpathological conditions enumerated in the tabulation of white medical cases only, and these we find to be 678. The corresponding numbers for the other groups of cases are as large, if not larger. The tabulation for the first time presents in a strictly scientific manner the distribution of morbidity, arranged on a plan which has the sanction of Bellevue Hospital and which has been adopted by many other hospitals throughout the country. As far as practicable, the classification conforms to the international classification of causes of death. The adoption of this classification by all of the principal hospitals throughout the country, and in conformity to the methods suggested by the author of this work, would unquestionably constitute a memorable advance in hospital administration and the practical utility of hospital results.

The seventh section consists of a number of special tables, including four on malignant tumors in detail, with admission and mortality rates, three tables on the Baltimore population and mortality statistics according to sex and race, one table on the statistics of days' treatment at Johns Hopkins for the twenty years ending with 1911, and nine tables on dispensary statistics, followed by one

on the statistics of x-ray treatment, radiographs, and fluoroscopic examinations, limited, however, to the period 1903-1911.

The eighth section gives the financial statistics of the hospital.

Appended to the text of the report is a bibliography of papers and references to hospital statistics, and the nomenclature and registration of diseases.

The analysis proper of the Johns Hopkins experience brings out many important facts of profound interest to the medical and surgical professions as well as to the laity. From the wealth of useful and instructive information contained in the work, which constitutes practically a cyclopedia of reference on the subject of hospital experience data, only the following can be very briefly referred to:

In appendicitis the fatality rate for white male patients was 3.5 percent, and for white female patients, 1.2 per cent. For colored male patients the corresponding rate was 11.8, and for colored females, 10.5. A similar disparity in the rates is observed when the required distinction is made as regards medical, surgical, and gynecological cases.

In the case of tumors the mortality rate has been as follows: for benign tumors the rate was 10.5 percent for white male patients against 5.2 percent for white female patients; and in the case of malignant tumors, 15.0 percent for white males and 10.7 percent for white females. For colored patients the fatality rate in benign tumors was 5.9 percent for males, and 4.0 percent for females; and in malignant tumors, 26.1 percent for males and 11.3 percent for females. In proportion to population, the admission rate for malignant tumors was 4.8 per 10,000 population for white males and 4.2 for white females. For colored patients the corresponding admission rates were 3.2 for males and 4.5 for females. Combining benign and malignant tumors, the respective admission rates for the decade ending with 1911 were 6.74 per 10,000 for white males, 7.32 for white females, 4.51 for colored males, and 15.56 for colored females.

Of the total number of admissions, the proportion of admissions for benign and malignant tumors was 8.4 percent for white males, 10.4 percent for white females, 4.5 percent for colored males, and 12.2 percent for colored females. In the case of white males the principal cause of admission was infectious diseases, accounting for 16 percent of the total; in the case of white females, diseases of the reproductive organs, accounting for 20.8 percent; in the case of colored males, infectious diseases, represented by 26.5 percent; and in the case of colored females, obstetrical conditions, accounting for 30.6 percent.

The financial statistics of the hospital, though discussed very briefly, are of considerable interest. The average gross cost per patient treated per day increased from $2.88 in 1907 to $3.61 in 1911, and the average net cost increased from $1.26 to $1.69 during the same period. The average number of days' treatment, however, decreased from 24.2 days during the first decade to 22.1 during the last; in 1911 the average duration was only 19.3 days.

The author concludes this notable contribution to the science of hospital administration with the following appeal to the hospital profession throughout the United States for uniformity in statistical methods and the adoption of the Bellevue classification of diseases:

"By presenting the experience of a large hospital, typical of modern methods of medical and surgical treatment, in a convenient form, I feel that a basis has been provided for a beginning, at least, in modern uniform hospital statistics, which are absolutely necessary as an aid toward the study of medical problems in their relation to broad questions of public policy. It is also to be hoped that as the result of this investigation the hospitals may be induced to adopt the Bellevue Hospital classification as practically the most suitable for medical and other purposes. In return, the hope may be indulged that Bellevue Hospital, and other great hospitals throughout the country as well, may be induced to adopt in their reports the method of statistical presentation which has been successfully carried forward from year to year by the Johns Hopkins Hospital from its beginning, and which, if adopted by other institutions, would bring order out of chaos and make the enormous amount of hospital experience really useful to the student of medicine, as well as of many other branches of learning, vitally interested in the facts, which have a much broader social and economic significance than is usually assumed to be the case."

The preparation of such a work would hardly have been possible but for the author's professional connection with a great life insurance company, which for many years has been foremost in fostering and encouraging statistical research in the underlying causes of American mortality and morbidity, and the economic problems resulting therefrom in their special relation to insurance. The scientific work done by this company has been properly recognized on numerous occasions by international juries, and awards granted to its exhibits of medical statistics at international expositions, but we venture to say that in the aid rendered in the preparation of the present volume the company has done vastly more for the Johns Hopkins Hospital than would have been possible by a very substantial direct financial contribution. The work of the author is too well known to require special praise, but it may not be inappropriate to add that the work is dedicated by him to Sir William Osler in appreciation of his friendship and constant encouragement of the statistical method in medicine.

Friend of Patient In Operating Room.

The following letter was published in the Journal of the American Medical Association of November 15. There are many more reasons why friends of patients should never be admitted to the operating room, but the two cases cited are sufficient reasons:

"A rather sad but unique accident occurred in my service at Harper Hospital, Detroit, October 30, which answers this question most convincingly in the negative. A friend of a patient insisted on being admitted to the operating room. He was told that the privilege was not allowed by the rules of the hospital, but could not understand why it should be denied him. He maintained that as long as his own daughter was the nurse in charge of the case, and that the patient to be operated on was a dear friend, he surely would be able to withstand the strain of the operation without any evil effect, and after some discussion he was finally admitted. During the course of the operation this friend fainted, striking his head on the mosaic floor. He bled from the nose and ears, and röntgenoscopy revealed a T fracture of the base of the skull. His condition is still critical.

"Another even more disastrous accident occurred at the Kalamazoo Hospital not very long ago. In this case the patient's relative felt a feeling of faintness coming over him, and in order to rid himself of the disagreeable sensations walked over to an open window for more fresh air. He sat on the window-sill and while sitting there fainted away completely. He fell out of the window, and in falling sustained a fracture of a cervical vertebra which proved fatal.

"I cite these two cases just to show what evil results may follow the unnecessary practice of admitting friends of patients to the operating room.

"ANGUS MCLEAN, M. D., Detroit."

A hospital to accommodate 40 beds, to be known as the Red Cross Hospital, and to be used for general hospital purposes, is to be built at San Mateo, Cal.